



BOARD OF BEHAVIORAL SCIENCES
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MEETING NOTICE

November 16-17, 2006

Handlery Union Square Hotel
351 Geary Street
San Francisco, CA 94102
(415) 781-7800

Thursday, November 16
9:30 a.m.

FULL BOARD OPEN SESSION - Call to Order & Establishment of a Quorum

- I. Chairperson's Report
- II. Executive Officer's Report
 - A. Personnel Update
 - B. Report on MHSA Education and Training Workgroups
 - C. Examination Update
 - D. Custody Evaluator Issues
 - E. Miscellaneous Matters
- III. Approval of July 27, 2006 Board Meeting Minutes
- IV. Election of Vice Chair
- V. Report of the Consumer Protection Committee
 - A. Recommendation 1 – Invite Association of Social Work Boards (ASWB) to Discuss National Exam for Clinical Social Workers
 - B. Recommendation 2 – Propose to Amend Title 16, California Code of Regulations Sections 1887(a), 1887(b), 1887.2(a), and 1887.3(a) Regarding Continuing Education Course Requirements
 - C. Recommendation 3 – Sponsor Legislation to Add Violations of the Health and Safety Code Regarding Patient Records and Violations of the Telemedicine Statute to the Definition of Unprofessional Conduct
 - D. Presentation by Bobby Pena and Phil Perry on Communications Contract
 - E. Review and Adoption of Board Logo Design
 - F. Strategic Plan Update
 - G. Enforcement Statistics
- VI. Presentation on Board Budget

1:00 p.m. VII. PUBLIC HEARINGS ON PROPOSED AMENDMENTS TO REGULATIONS

Regulations subject to proposed amendment:

Notice #1 (Supervisor Qualifications/Requirements):

Amend Section 1833.1 – Requirements for Supervisors
Amend Section 1870 – Requirements for Associate Clinical Social Worker Supervisors

Notice #2 (Continuing Education Providers):

Amend Section 1816.7 – Delinquent Fees
Amend Section 1887.7 – Board Approved Providers
Adopt Section 1887.75 – Renewal of Expired Approval
Adopt Section 1887.77 – Time Limit for Renewal of Approval After Expiration; New Approval

Notice #3 (Abandonment of Application Files, Fees, and Technical Clean Up):

Amend Section 1805 - Applications
Amend Section 1806 – Abandonment of Application
Repeal Section 1833.3 – Re-Examination

Amend Section 1816 – Renewal Fees
Amend Section 1816.1 – Initial License and Registration Fees
Amend Section 1816.2 – Written Examination and Re-Examination Fees
Amend Section 1816.4 – Examination Application Fees
Amend Section 1816.6 – Inactive License Fees

Amend Section 1854 – Equivalent Degrees
Repeal Section 1855 – Equivalent Experience in Pupil Personnel Services
Amend Section 1856 – Experience Equivalent to Three (3) Years Full-Time Experience as Credentialed School Psychologist
Repeal Section 1857 – Experience Equivalent to One Year of Supervised Professional Experience
Amend Section 1858 – Unprofessional Conduct

CLOSE OF PUBLIC HEARING

- VIII. Review and Possible Action on Proposed Amendments to 16CCR1803 Regarding Delegation to the Executive Officer
- IX. Review and Possible Action on Proposed Amendments to 16CCR1833.1 & 1870 Regarding Supervisor Qualifications
- X. Review and Possible Action on Proposed Amendments to 16CCR1816.7, 1887.7, 1887.75, & 1887.77 Regarding Continuing Education Providers
- XI. Review and Possible Action on Proposed Amendments to 16CCR1805, 1806, 1833.3, 1816, 1816.1, 1816.2, 1816.4, 1816.6, 1854, 1855, 1856, 1857, & 1858 Regarding Application Files, Fees and Licensed Educational Psychologists
- XII. Report of the Policy and Advocacy Committee
 - A. Recommendation #1 – Revisions to Section 4980.90 Relating to Out-of-State Applicants for MFT Licensure
 - B. Recommendation #2 – Reduce License Delinquency Period to Three Years

- C. Recommendation #3 – Eliminate Extensions for Associate Clinical Social Worker Registrations
- D. Regulation Update
- E. Legislation Update
- F. Strategic Plan Update
- G. Budget Update
- H. Quarterly Licensing Statistics

XIII. Public Comment for Items Not on the Agenda

Friday, November 17
9:30 a.m.

FULL BOARD OPEN SESSION - Call to Order & Establishment of a Quorum

FULL BOARD CLOSED SESSION

- XIV. Pursuant to Section 11126(a) of the Government Code to Evaluate the Performance of the Board's Executive Officer.

FULL BOARD OPEN SESSION

- XV. Report of the MFT Education Committee
- XVI. Presentation Regarding Title Protection for Mental Health Professionals and Certified Alcohol and Drug Abuse Counselors Specialized in Dual Diagnosis Care.
 - Kathryn Jett, Director of the Department of Alcohol and Drug Programs
- XVII. Discussion and Possible Action Regarding Proposal to Establish Title Protection for Mental Health Professionals and Certified Alcohol and Drug Abuse Counselors Specialized in Dual Diagnosis Care.

Public Comment on items of discussion will be taken during each item. Time limitations will be determined by the Chairperson. Items will be considered in the order listed. Times are approximate and subject to change. Action may be taken on any item listed on the Agenda.

THIS AGENDA AS WELL AS BOARD MEETING MINUTES CAN BE FOUND ON THE BOARD OF BEHAVIORAL SCIENCES WEBSITE AT www.bbs.ca.gov

NOTICE: The meeting facilities are accessible to persons with disabilities. Please make requests for accommodations to the attention of Christina Kitamura at the Board of Behavioral Sciences, 1625 N. Market Blvd., Suite S-200, Sacramento, CA 95834, or by phone at (916) 574-7835, no later than one week prior to the meeting. If you have any questions please contact the Board at (916) 574-7830.

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AGENDA ITEM II

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**State of California
Board of Behavioral Sciences**

Memorandum

To: Board Members **Date:** November 3, 2006
From: Paul Riches
Executive Officer **Telephone:** (916) 574-7840
Subject: **Agenda Item II. - Personnel Update**

Departures

- Kim Madsen, who served as Program Manager, left the board on August 18, 2006. Kim is now the Enforcement Manager for the Board of Barbering and Cosmetology.
- Tricia Soares, who served as a marriage and family therapist license evaluator, left the Board on November 3, 2006. Tricia is now a staff services analyst at the State Personnel Board.
- Tori Gaines, who served as a social work license evaluator, left the Board on November 3, 2006. Tori is now a management services technician at the Board of Barbering and Cosmetology.

New Hires

- Steve Sodergren joined the Board as program manager on September 18, 2006. Steve previously worked at the Department of Health Services as an associate governmental program analyst for the Medi-Cal Procurement Branch.
- Marsha Gove joined the BBS on September 25, 2006 filling one of two vacant Office Technician positions in the cashier unit. Marsha has been with DCA since 1996 and has worked in licensing and cashiering.
- Lora Romero joined the BBS staff on July 24, 2006, filling one of the part-time Office Assistant positions. Lora is new to state service and recently worked as the catering manager for the River Cats group events.
- Candis Montoya joined the BBS staff on August 7, 2006, filling the part-time Office Assistant position. Candis is a reinstatement to state service and previously worked at the Board of Equalization.

Vacant Positions

- Licensing Unit-Office Technician (Typing): We have held interviews and have made a tentative offer to a candidate to fill the MFT evaluator position.
- Licensing Unit-Office Technician (General): We have submitted paperwork to re-class this position as a Office Technician (Typing) so that Terri Maloy, who is currently the LEP evaluator, can be re-assigned to this position.
- Cashiering-Office Technician (Typing): We have held interviews and are currently waiting approvals from personnel to make a tentative offer.

- Licensing-Office Technician (Typing): Due to the re-assignment of Terri Maloy, this position will be vacant. The recruitment process will begin the week of November 6.

Item II. B.

**MHSA Five-Year Strategic
Plan**

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**CALIFORNIA DEPARTMENT OF
MENTAL HEALTH**

**MENTAL HEALTH SERVICES ACT
WORKFORCE EDUCATION AND TRAINING
FIVE-YEAR STRATEGIC PLAN**

DRAFT 9-25-2006

FOR DISCUSSION ONLY

The Mental Health Services Act (Act) stipulates that California will develop a five-year education and training development plan (Five-Year Plan). This second draft incorporates stakeholder input of the first draft, reports on accomplishments to date, and proposes actions for implementation in the near-term. Inserts such as this are interspersed throughout the document to provide a commentary on the parts of the Five-Year Plan. This Five-Year Plan will remain in draft form until an inclusive stakeholder process is completed for all parts of the Plan.

Fiscal Year 2005-06 through Fiscal Year 2009-10

**Mental Health Services Act
Workforce Education and Training
Five-Year Strategic Plan**

September, 2006

**Arnold Schwarzenegger
Governor**

**Kimberly Belshe
Secretary, Health and Welfare Agency**

**Stephen W. Mayberg, Ph.D.
Director, California Department of Mental Health**

**California Department of Mental Health
1600 9th Street
Sacramento, California 95814**

EXECUTIVE SUMMARY

The Executive Summary will be written by the Director of the Department of Mental Health (The Department), and will summarize the Five-Year Plan, how it was developed, and how it will be implemented. The Department is responsible for the development of the Five-Year Plan, with review and approval by the California Mental Health Planning Council (Council), and oversight by the Mental Health Services Oversight and Accountability Commission (Commission). The Department will follow an inclusive stakeholder process, by which all interested individuals will be invited to participate in the development of this plan, and to comment upon all regulations, policies, practices and use of funds earmarked for education and training activities within the purview of the Act.

STEPHEN W. MAYBERG, Ph.D., Director

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Mission Statement _____

Core Values _____

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Statewide Needs Assessment _____

Goals and Objectives _____

Accomplishments and Actions _____

Accomplishments _____

The above section will list the education and training activities that were planned and accomplished to date. This primarily consists of stakeholder participation in the development of the Five-Year Plan, and early implementation of activities consistent with the intent of the Act. The following section will list Actions for fiscal year 2006/07 that will lead to the development of a workforce capable of providing public mental health services as envisioned by the Act. These Actions and Accomplishments will be reviewed and adjusted annually, with a yearly report of each year's Accomplishments and Actions for the duration of the Five-Year Plan.

Actions for FY 2006-07 _____

Resources _____

This section will depict resources allocated to the Education and Training Fund, as well as funds budgeted by each county for education and training activities. Annual updates will reflect expenditures as well as budget adjustments for succeeding years.

Appendices

Appendix A: Statewide Agreements _____

This section will summarize contracts, interagency agreements, and memoranda of understandings that are executed and administered by the Department that contribute to the accomplishment of objectives listed in the Five-Year Plan.

Appendix B: County Plans _____

This section will summarize county needs assessments and program and expenditure plans pertaining to education and training activities.

Appendix C: Stakeholder Process _____

This section will document input by all interested individuals through meetings, forums and Departmental website calls for comment.

INTRODUCTION

In November of 2004 the people of California enacted the Mental Health Services Act (Act) in order to build a better public mental health system of care. A component of the Act is to establish an education and training program with dedicated funding to remedy the shortage of qualified individuals, and to implement a five-year education and training development plan.

The California Department of Mental Health (Department), in partnership with its stakeholders, has created a five-year strategic planning process as a means to implement this component of the Act. The key elements of this Five-Year Plan are 1) the mission, core values and vision that are consistent with the intent of all components of the Act, 2) a comprehensive statewide workforce education and training needs assessment, 3) goals and objectives stipulated by the Act, 4) a continuous five-year planning cycle of actions, with a yearly report of accomplishments, and 5) a yearly report of resource assumptions, to include the Education and Training Fund. Finally, statewide and county agreements, programs and plans are described in the appendices, with a documentation of the process of stakeholder inclusion that was undertaken in the development of the Five-Year Plan.

MISSION

The California public mental health community services and supports system, in partnership with all its stakeholders, will develop and maintain a sufficient workforce, to include consumers and family members, capable of providing consumer- and family-driven, culturally competent services that promote wellness, recovery, and resiliency, and lead to evidence-based, values-driven outcomes.

CORE VALUES

The following core values encompass all activities pursuant to the Act, to include workforce education and training:

- Promote wellness, recovery and resilience.
- Increase consumer and family member involvement in policy and service development, and employment in service delivery.
- Develop a diverse, culturally sensitive and competent workforce in order to increase the availability and quality of mental health services and supports for individuals from every cultural group.
- Deliver individualized, consumer and family-driven services that are outcome oriented and based upon successful or promising practices.
- Outreach to underserved and unserved populations.

VISION STATEMENT

This leadership guidance was derived from a keynote speech provided by the Director of the Department of Mental Health, Dr. Stephen Mayberg, at a statewide education and training policy forum.

- Leadership. The Act has provided both a mandate and an opportunity for transforming the public mental health system. Transformative change starts with the people who have the capacity and passion to excel and mentor the practices, approaches and treatments that are sensitive and responsive to consumers' needs and cultures, and produce more favorable outcomes. The Five-Year Plan needs to recognize and support those successful individuals, programs and practices.
- Responsiveness. All service disciplines must be sufficiently staffed to meet California's community services and support needs at all levels of education and experience; from peer and family supports to licensed professionals.
- Inclusion. The Five-Year Plan needs to reflect an ongoing process that positively engages all individuals who can impact the mental health system workforce. This includes a) outreaching to present and

future mental health service providers, b) engaging all stakeholders in planning and decision-making, c) partnering with all education and training institutions, internship programs and potential entities capable of addressing workforce needs, and d) engaging the public.

- Fidelity. Both curricula and methods of teaching at all levels of education and training need to adhere to an agreed upon set of curricula and methods of teaching that appropriately integrate theory and practice, and are based upon the Five-Year Plan's Core Values. A consistent mental health career pathway should facilitate navigation from entry level through licensed professional occupations, while allowing entry into the workforce at any level.
- Relevance. Finally, the Five-Year Plan should be a permanent means to incrementally improve the workforce, with accountability at all levels. This involves planning, resourcing, implementing and evaluating on an ongoing basis to realistically reflect both emerging program developments and fiscal constraints. It should also balance the appropriate level of education and training provided at the community, regional and statewide levels.

STATEWIDE NEEDS ASSESSMENT

Background. California faces a significant shortage of individuals capable of delivering the public mental health services envisioned by the Act. Previous studies have pointed to high vacancy rates in certain occupational classifications, lack of diversity in the workforce, poor distribution of existing resources, and under-representation of consumers and family members in the provision of services and supports. The workforce also needs the skills to deliver services and supports that emphasize wellness, recovery and resilience, and that result in positive outcomes.

The historical lack of sufficient public mental health funding has challenged county and contract agency administrators to creatively adjust their capacity to deliver services to available resources. In addition, the traditional emphasis on treating symptoms rather than promoting strengths has resulted in a workforce composition that meets licensing and credentialing

requirements which are more responsive to a more “medical model” approach. For the Act to fulfill its mandate to transform mental health service delivery the composition and capabilities of the workforce that provides the services must also transform. For example, the projection of numbers of individuals in occupational categories in the next five years will likely include a transformation within the categories themselves.

The needs assessment included in this Five-Year Plan will need to address current workforce requirements as well as include a workforce projection methodology consistent with the transformative vision of the Act. The following issues, among others, will influence the development of the needs assessment and guide the Department in constructing a model that assists in funding education and training programs:

- The public mental health system must be relevant and responsive to underserved and unserved populations, and be deployed to meet needs not presently reflected in current perceived vacancy rates.
- Ethnic diversity, linguistic capacity, and cultural competence of the workforce will need to keep pace with the changes in ethnic and monolingual populations.
- Changes in how services are delivered as a result of the Act may affect licensure and credentialing requirements.
- Emerging best practices, which are consistent with the values of the Act, may change regulations and policies governing the composition of the workforce, as well as related recruitment, training and education.
- Identifying occupational functions rather than focusing on specific classifications of mental health service providers will influence the current service provider-to-population ratios.
- The enrollment capacities of educational programs will need to be considered in planning the strategic use of education and training funds.

The dynamic nature of these variables dictate an ongoing participatory research approach to the development of the needs assessment, ensuring that the values of stakeholders are included and operationalized in the methodology used to project future workforce needs.

Workforce needs generated by the Act. Pursuant to local stakeholder planning processes county mental health programs have begun implementing community services and supports (CSS) plans. The Act requires that each county mental health program submit a needs assessment identifying the anticipated increases in each professional and other occupational category needed to provide the projected increase in services to consumers and their families.

Submitted county CSS Plans were summarized and analyzed for new MHSA workforce positions, stated needs and challenges, and cultural diversity and language proficiency issues.

Statewide estimates indicate that over 4,300 new positions are being created with initial MHSA funding, with the following service provider occupational classifications reported:

- 5% - Psychiatrists and other physicians
- 9% - Nursing personnel
- 15% - Social workers
- 5% - Psychologists
- 17% - Therapists or counselors
- 21% - Case managers
- 17% - Mental health workers
- 9% - Other occupations

Over 20 percent of all of the new MHSA positions have been specifically designated to be filled by consumers and/or family members. While employing significant numbers of the more traditional occupations, the above numbers delineate a movement toward a different workforce composition than currently exists. This creates a need for responding to challenges in recruiting and retaining the traditional occupations, as well as recruiting, training and supporting individuals to fill newly created positions.

Counties reported the following recurring challenges:

- Language proficiency, cultural competency, and diversity of the workforce. Individuals with Hispanic/Latino heritage are uniformly underrepresented in the workforce. Counties reported a need to attract and retain staff who are bicultural and bilingual, especially in

Spanish. Urban areas present discrete immigrant populations that pose cultural competency and language proficiency challenges. Native American tribes and rancherias continue to be underserved due to cultural differences.

- Organizational capacity to support new services. Due to a history of chronic under funding of public mental health, counties and contract agencies lack the infrastructure to administratively support the significant addition of new workers and programs.
- Geographical challenges of recruiting staff and reaching consumers. County mental health programs have responded to stakeholder input to field programs dedicated to underserved and unserved populations. These new programs now face the challenge of finding workers willing and able to work in remote areas as well as communities that are not able to compete economically for a limited pool of qualified workers.
- Hiring consumers and family members. The Act has created a significant number of service provider positions for consumers and family members. Counties have indicated a number of challenges in incorporating these new positions into their existing workforce. These challenges include role transition from consumer to provider, reasonable accommodations, ongoing employment supports to new employees to navigate changes in public benefits, and incorporation of positions into civil service classifications to facilitate career progression.
- Recruiting and retaining licensed staff. The public mental health system has experienced a chronic shortage of individuals capable of prescribing and administering psychotropic medications, diagnosing serious mental illness, and signing treatment plans. The addition of new MHSA funded programs has exacerbated the problem.

Thus, the challenges in developing a capable workforce for new MHSA services has provided useful information with which to initially plan and implement actions to address these challenges, and ultimately to respond to the entirety of California's community public mental health workforce.

The Department is working with consultants and stakeholders to develop a strategy for conducting a comprehensive needs assessment of the entirety of California's community public mental health workforce. The intent is to measure workforce

need, capacity to meet the need, and provide valid data to facilitate workforce education and training planning and allocation of resources. Also, an ongoing evaluative process will be developed to measure progress toward meeting workforce needs over time.

GOALS AND OBJECTIVES

The purpose of the following Goals and Objectives is to provide a structure for the creation of a realistic set of actions for California's public mental health community to accomplish in order to positively influence the workforce, and thereby improve the quality of services and supports received by individuals and their families.

The Goals listed are limited in number, and provide broadly defined strategic directions. The Objectives are a specific set of outcomes that have been stipulated by the Act to be included in the Five-Year Plan, and are proposed to accomplish each broad Goal.

Goal #1 – Develop sufficient qualified individuals for the public mental health workforce.

Objective A: Expand the capacity of postsecondary education programs to meet the needs of identified mental health occupational shortages.

Objective B: Expand loan forgiveness and scholarship programs offered in return for a commitment to employment in California's public mental health system. Extend these programs to interns and current employees of the mental health system who want to obtain Associate of Arts, Bachelor, Masters and Doctoral degrees.

Objective C: Create stipend programs for persons enrolled in academic institutions who want to be employed in the public mental health system.

Objective D: Promote the employment of consumers and family members at all levels in the mental health system.

Goal #2 – Increase the quality and success of educating and training the public mental health workforce in the expressed values of the Act.

Objective E: Develop curricula to train and retrain staff to provide services in accordance with the expressed values of the Act.

Objective F: Promote the inclusion of cultural competency in all training and education programs.

Goal #3 – Increase the partnership and collaboration of all entities involved in public mental health workforce education and training.

Objective G: Establish regional partnerships within the public mental health and educational systems in order to expand outreach to multicultural communities and increase the diversity of the public mental health workforce, reduce the stigma associated with mental illness, and promote the use of web-based technologies and distance learning techniques.

Objective H: Increase the prevalence of mental health career development opportunities in high schools, adult education and regional occupational programs, such as health science and human service academies, in order to recruit students for public mental health careers.

Objective I: Promote the meaningful inclusion of mental health consumers and family members, and incorporate their viewpoints and experiences in all training and education programs.

ACCOMPLISHMENTS AND ACTIONS

1. Accomplishments

A. Enacted Public Planning Process. Upon passage of the Mental Health Services Act the Department of Mental Health engaged in a public planning process to facilitate maximum participation by the broadest group of participants, or stakeholders, in transforming community public mental health service delivery in California. The Department, in partnership with its stakeholders, developed a process and set of guiding principles by which policy and decision-making could be accomplished in as inclusive and transparent manner as possible. Key to these guiding principles was 1) implementing practices that would ensure active participation by consumers

and family members in order to incorporate their viewpoints and experiences, and 2) promoting the inclusion of cultural competency throughout all activities connected to the Act.

Within this context the MHSWA workforce education and training component embarked upon a public planning process, beginning with a series of three statewide forums (June of 2005 in Sacramento, February 2006 in Newport Beach, and April 2006 in Sacramento and Anaheim) for the public to provide input on what was needed and how to address California's workforce education and training challenges.

A statewide advisory body was formed that included leaders and subject matter experts from 1) statewide constituency organizations, such as the National Alliance for the Mentally Ill – California (NAMI), California Network of Mental Health Clients (CNMHC), California Mental Health Directors Association (CMHDA), United Advocates for Children of California (UACC), California Association of Psychosocial Rehabilitation Agencies (CASRA), California Mental Health Planning Council (CMHPC) and the Oversight and Accountability Commission (OAC), 2) educational institutions, and 3) professional organizations.

This advisory body assisted in the formation of special topic workgroups, each focusing upon one of the objectives outlined in the Five-Year Plan, and responsible for crafting a series of recommended actions for public consideration. Each workgroup was comprised of a cross-section of individuals representing county mental health, contract agencies, educational institutions, professional organizations, and consumers and family members. Participants articulated the issues and concerns of racial/ethnic groups, administration and service provider staff, and special populations/age groups being served.

B. Developed MHSWA Workforce Education and Training Infrastructure.

The Department formed an MHSWA Workforce Education and Training Unit that is responsible for facilitating and supporting the public planning process and writing and administering the Five-Year Plan. This unit works with the Human Resources Committee of the California Mental Health Planning Council and the Education and Training Committee of the Oversight and Accountability Commission to execute the statutory requirements of the Act for approval and oversight of the Five-Year Plan.

C. Implemented Early Education and Training Resources. MHSA funding was added to existing California resources recognized for their ability to immediately address training and workforce needs on a statewide basis.

- Organizational Change Support. The California Institute for Mental Health (CIMH) expanded its existing statewide training and technical assistance mission of supporting county mental health programs. This expansion included ongoing technical assistance for organizational movement toward values-driven, evidence-based service delivery as envisioned by the Act, and to facilitate regional learning collaborative networks to plan and implement new practices.
- Financial Incentive Program. The California Social Work Educational Consortium (CalSWEC) expanded its existing stipend program to provide financial incentives for students in masters level social work programs to commit to work in community public mental health. One hundred seventy-three graduates are now available for employment this year. This program provides a replicable model for development of additional financial incentive programs.
- Statewide Constituency Partnership. The statewide constituency organizations of the California Network of Mental Health Clients (CNMHC), United Advocates for Children (UACC), and the National Alliance for the Mentally Ill – California (NAMI) are expanding their efforts to reach consumers and family members with self-help technical assistance and train-the-trainer curricula, such as Educate, Equip and Support – Building Hope, Peer-to-Peer, Family-to-Family, and Wellness Recovery Action Planning. These curricula will promote the meaningful inclusion and employment of consumers and family members at all levels of the public mental health system.

Stakeholders are invited to provide input on the following proposed education and training Actions to be taken in the current fiscal year that address the above listed objectives. These are short-term strategies to address immediate needs, and provide incremental steps toward fully honoring the stipulations of the Act. For example, the funding of replicable models enables new programs and structures to be started that

can immediately address need, develop lessons learned, and provide assistance for the subsequent growth of programs and trainings to the level of established need.

2. Actions for FY 2006/2007

Objective A: Expand the capacity of postsecondary education programs to meet the needs of identified mental health occupational shortages.

- **Action #1.** Fund replicable model residency and internship programs that have the capacity to address critical shortages of individuals capable of prescribing and administering psychotropic medications and signing treatment plans.
- **Action #2.** Expand certification programs that produce individuals proficient in delivering community public mental health services that are in accordance with the intent of the Act.
- **Action #3.** Promote the development of continuing education unit (CEU) trainings to address services delivered in accordance with the intent of the Act.
- **Action #4.** Provide funding that enables release time for community public mental health service providers and education faculty to work together in their respective settings to impact curricula and stigma, and promote wellness, recovery and resiliency. Fund consumers and family members to participate in faculty and staff exchanges at the workplace and in educational settings.

Objective B: Expand loan forgiveness and scholarship programs offered in return for a commitment to employment in California's community public mental health system. Extend these programs to interns and current employees of the mental health system who want to obtain Associate of Arts, Bachelor, Masters and Doctoral degrees.

- **Action #5.** DMH to partner with the Health Professions Education Foundation (HPEF) to develop an MHSA scholarship and loan forgiveness program modeled after existing statewide programs.
- **Action #6.** DMH to partner with the Office of Statewide Health Planning and Development (OSHPD) to maximize federal funding to

California for existing scholarship and loan forgiveness programs in designated mental health profession shortage areas.

Objective C: Create stipend programs for persons enrolled in academic institutions who want to be employed in the public mental health system.

- Action #7. In addition to CalSWEC expand the capability of additional occupational professions to develop stipend programs.

Objective D: Promote the employment of consumers and family members at all levels in the mental health system.

- Action #8. Fund replicable model community public mental health entry level preparation programs for consumers and family members.
- Action #9. Expand existing statewide contracts to CNMHC, NAMI, UACC and trainers/consultants to California's Mental Health Cooperative Programs to focus development in the areas of a) career advancement, or pipeline strategies, for consumer and family member designated positions, b) alternate civil service minimum qualifications to honor consumer, family member lived experience, c) agency assessment of readiness to support consumer and family members in the workplace, d) essential elements of ongoing employment support, and e) preparation to run consumer and family member operated programs.
- Action #10. Expand the functions of the consumers and family members who participate in the DMH expert pool, and establish similar expert pools at regional levels.

Objective E: Develop curricula to train and retrain staff to provide services in accordance with the expressed values of the Act.

- Action #11. Establish an ongoing MHSA education and training coordinating council comprised of leadership from county mental health programs and their contract agencies, professional organizations, education and training institutions, and consumers and family members. This council would provide guidelines and principles for training and technical assistance tracks and topics appropriate under the Act, and review and comment on core competencies and curricula.

Objective F: Promote the inclusion of cultural competency in all training and education programs.

- Action #12. Cultural competency is a cross-cutting objective that is proactively addressed in all goals and objectives. All MHSA funded education and training will be required to address how their program/training will include the principles and practices of cultural competency.

Objective G: Establish regional partnerships within the mental health and educational systems in order to expand outreach to multicultural communities and increase the diversity of the mental health workforce, reduce the stigma associated with mental illness, and promote the use of web-based technologies and distance learning techniques.

- Action #13. Fund initial regional partnership structures throughout California as replicable models, and support the establishment of additional regional partnerships, as locally determined.
- Action #14. Convert MHSA relevant trainings into a blended learning format to enable web-based access throughout California.

Objective H: Increase the prevalence of mental health career development opportunities in high schools, adult education and regional occupational programs, such as health science and human service academies, in order to recruit students for mental health careers.

- Action #15. Fund the planning process for the establishment of replicable model mental health career pathway programs.

Objective I: Promote the meaningful inclusion of mental health consumers and family members, and incorporate their viewpoints and experiences in all training and education programs.

- Action #16. Inclusion of consumers and family members is a cross-cutting objective that is proactively addressed in all objectives. All MHSA funded education and training will be required to address how their program/training will include the viewpoints and experiences of consumers and family members.

RESOURCES

APPENDICES

- 1. Appendix A: Statewide Agreements**
- 2. Appendix B: County Plans**
- 3. Appendix C: Stakeholder Process**

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Item II. B.

MHSA Workforce Study

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Statewide Workforce Needs by Occupational Classification and Diversity Challenges, as Reflected in Community Services and Support (CSS) Plans

Prepared for:

Education and Training Unit
California Department of Mental Health
1600 9th Street
Sacramento, CA 95814

Prepared by:

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July 31, 2006

Statewide Workforce Needs by Occupational Classification and Diversity Challenges, As Reflected in Community Services and Support (CSS) Plans

Executive Summary

Background

The Mental Health Services Act (MHSA) requires that each county must submit to the Department of Mental Health (DMH) a needs assessment identifying the anticipated increases in each professional and other occupational category needed to provide the projected increase in services to consumers and their families.

Study Aim

An analysis of submitted county Community Services and Supports (CSS) Plans was undertaken in order to enable appropriate initial allocation of MHSA education and training funds to recruit, train and retain sufficient individuals to deliver CSS Plan services as envisioned by the MHSA.

Methods

Thirty-six county CSS Plans were summarized and analyzed for new MHSA workforce positions, stated needs and challenges, diversity and language proficiency issues, and proposed one-time funds allocated for education and training. Plan summaries were either approved or close to final approval at the time of analysis. Sufficient counties in all five California Mental Health Director's Association (CMHDA) regions were represented in order to enable the use of extrapolation factors to estimate regional and statewide totals.

Limitations

Coordinating instructions to the counties for submission of CSS Plans did not provide any standardized language specific to conveying workforce information, as the focus was on proposing new MHSA services. Consequently there was variance in the method and description of new positions, workforce diversity, and proposed use of one-time funds. Also, analyzed CSS Plans that were not yet approved as final could be subject to changes due to the approval process.

Results

Statewide totals indicate an estimated 4,332 new positions (FTE) are being created, with 81 percent for direct service, 13 percent for support staff, and six percent for supervisory or management. At least 20 percent of the new jobs are specifically designated for consumers and family members.

Of the estimated 3,525 direct service positions, five percent will be for psychiatrists and other physicians, nine percent nursing personnel, 15 percent social workers, five percent

psychologists, 17 percent therapists or counselors, 21 percent case managers, 17 percent mental health workers, and nine percent in a variety of other job titles.

Compared with the general population Hispanics/Latinos are underrepresented in the public mental health workforce by approximately 17 percent. The recurring challenge as reported by CSS Plans is attracting and retaining staff that are bilingual and bicultural, especially Spanish. Staff with other language proficiencies, mostly specific Asian languages, Russian, Armenian, Farsi and Arabic are also in short supply in large urban areas and the Central Valley.

The top five workforce needs and challenges reported were (1) language proficiency, cultural competency, and diversity of the workforce, (2) organizational capacity to support new services, (3) geographical challenges of recruiting staff and reaching consumers, (4) hiring consumers and family members, and (5) recruiting and retaining licensed staff.

It is estimated that California counties plan to spend about \$18.6 million in one-time CSS funds for a broad number of activities designed to address workforce needs to implement programs; to include training in evidence-based practices, wellness, recovery and resiliency, cultural competence and serving special populations and age groups. Several proposed training for families of young children, adult consumers and family members. Some stipends for interns and others were proposed. Other proposed use of one-time funds were for program development or redesign of existing efforts, experiential learning with educational institutions, and distance learning.

Discussion

Counties have sufficiently articulated their workforce challenges in recruiting, training and retaining staff in order to underscore the need to apply MHSA workforce education and training resources in a timely manner. Counties need resources to attract and retain a more diverse workforce, train new staff in cultural competency and wellness, recovery and resilience, and need assistance with the hiring, transition and ongoing support of a significant number of consumers and family members who will be working in the public mental health system.

Implications for Policy and Research

This needs assessment study can be used to supplement concrete education and training program proposals for assisting the recruitment, hiring and training counties need to accomplish for implementing their CSS Plans. A more comprehensive needs assessment needs to be conducted in order to project public mental health needs into the future and evaluate the impact of the application of MHSA education and training resources over time.

Statewide Workforce Needs by Occupational Classification and Diversity Challenges, As Reflected in Community Services and Support (CSS) Plans

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In November 2004, California voters passed Proposition 63, now known as the *Mental Health Services Act (MHSA)*, or *Act*. The Act imposed a one percent tax on personal incomes of over one million dollars. In August 2005, the California Department of Mental Health (DMH, 2005) issued a Policy Letter¹ to counties for their use in preparing their Community Services and Supports (CSS) plans. These plans cover proposed expenditures for the following three fiscal years (FYs): FY 2005-06, FY 2006-07, and FY 2007-08. In February 2006, DMH asked the counties to plan within an overall total of \$969 million.²

Introduction

This study summarizes information from Community Services and Support (CSS) Plans. The questions we seek to answer fall within the following categories:

NEW MHSA WORKFORCE POSITIONS

1. How many and what kinds of positions will be created to implement CSS plans?
2. Into which of the following occupational classifications do these new workforce positions fall?
 - a. Positions designed to be filled by consumers/family members;
 - b. Service provider positions; or
 - c. Supervisors, program managers, and staff support staff positions.

* I thank my Research Assistant, Tyler Heid, a student at UC-Davis, for his work in tabulating and organizing information for this report. I am also grateful for assistance from my business partner, Bill Allen, and the DMH Team overseeing workforce education and training – Warren Hayes, Wendy Desormeaux, and Inna Tysoe. Wendy and Inna put together the CSS plan summaries, from which much of the information in this report has been drawn.

¹ A Policy Letter is an addendum to CMH's Contract with Counties.

² Dollar amounts are shown in Enclosure 1 to DMH Letter 06-03, which can be found at <http://www.dmh.ca.gov/DMHDocs/docs/Letters06/06-03.pdf>

3. What are some of the challenges counties face when job tasks, competencies, and qualifications differ from those in existing civil service positions?

RACE/ETHNICITY AND THRESHOLD LANGUAGES

4. How does the racial/ethnic composition of each county's public mental health workforce compare with the racial/ethnic composition of each county's population?
5. What *threshold [primary] languages*, other than English, are spoken in counties?

WORKFORCE NEEDS AND CHALLENGES

6. What do county CSS plan summaries say about *workforce needs and challenges*?

PROPOSED USE OF ONE-TIME FUNDS TO MEET WORKFORCE NEEDS TO IMPLEMENT PROGRAMS

7. What do county CSS plan summaries say about use of one-time funds for education, training, related human resource needs, and program development or, redesign?

Methods

This report is based on recent summaries of county CSS plans provided by DMH staff. Plans go through a series of reviews before they are approved and money is released to the county. This report is based on CSS plans for thirty-six counties. Plans for these counties had either been approved or were in the process of being approved when summaries were provided to the Contractor earlier in July 2006.

Is it appropriate to generalize about *statewide workforce* implications of CSS plans from a sample of 36 counties? We think it is because we have several counties in each of the multi-county regions.³ Thirty-five of the counties developed CSS plans based on three-year CSS budget allocations (dollar amounts) making up anywhere from 63 percent to 91 percent of total allocations for their multi-county region. Los Angeles submitted a plan and, as a result, all of Los Angeles Region is represented in the data. Appendix A groups all counties by region and specified specifies the proposed MHSA allocation by county and region.

³ The regions are geographically defined and are: Superior Counties; Southern Counties; Los Angeles County, Central Counties, and Greater Bay Area Counties.

Appendix A also shows *extrapolation factors* used to estimate regional and statewide totals. These factors are reciprocals of a fraction. The fraction is (1) CSS budget allocations for counties with CSS plan summaries divided by (2) CSS budget allocations for *all* counties in the region. Overall, the allocation for the 36 counties totaled \$808,259,811 out of a grand total of \$969,239,480 for all 58 counties. The reciprocal of this fraction is approximately 1.1991682. We use this *extrapolation factor* – as well as regional *factors* -- to “blow up” sample numbers to estimated statewide totals. In other instances – for example, reporting narrative information on *workforce challenges* – we indicate that the material is not extrapolated and relates only to the 36 counties for which we have CSS plan summaries.

Findings

Workforce positions to implement CSS plans

Overall. – The 36 CSS plan summaries identified 3,613 new full-time-equivalent (FTE) positions. When we applied extrapolation factors to regional totals, we estimated that all plans, when submitted, will call for approximately 4,332 FTEs. (See Table 1, which summarizes our calculations.)

Table 1. New MHSA Workforce Positions, by Region: Estimated Statewide Totals

Region	Total, New Posi- tions (FTE)	Percentage		
		Consumer/ family	Service provider	Adm, Sup, Support
		Number		
Bay Area	848	213	516	119
Southern.....	1,256	345	696	215
Los Angeles	1,419	84	976	359
Central.....	560	153	334	73
Superior.....	249	76	140	33
Total, statewide.....	4,332	871	2,662	799
		Percent		
Bay Area	100.0%	25.1	60.8	14.0
Southern.....	100.0	27.5	55.4	17.1
Los Angeles	100.0	5.9	68.8	25.3
Central.....	100.0	27.3	59.6	13.0
Superior.....	100.0	30.5	56.2	13.3
Total, statewide.....	100.0	20.1	61.4	18.4

Consumers and family. -- About 20.1% of new positions – or, approximately 871 out of 4,332 -- are to be filled by consumers or family members. Of this number, we estimate that about 29% are for consumers, 9% for family members, and the rest (63%) for either or both. (See Table 2.) These figures are somewhat speculative, because we assumed that position titles containing the term “peer” were generally “set aside” for individuals with psychiatric disabilities (consumers), rather than parents or other family members. Several job titles have *peer* or *consumer* in the title (e.g., Peer Specialist, Consumer Advocate Peer Mentor, Peer Advocate, Peer Support Aide, Peer Guide, Peer Coach, and Peer Counselor). Several job titles are in the area of employment or housing (e.g., Employment Specialist, Vocational Assistant, Employment Coordinator, Peer Housing Counselor, Peer Benefits Advocate, Consumer Vocational Activities Coordinator, Consumer Housing Activities Coordinator, and Employment Consultant). One county plans to have four volunteer senior Peer Counselors, as volunteers, receiving \$85 per month in stipends. Another county stated that: "The consumer and family positions are not labeled as such in the budget. At all levels of staffing qualified consumer and family members will be considered and hired. Consumer and family member status is a desirable qualification in all . . . [public mental health] positions."

Table 2. New MHSA Workforce Positions for Consumers and Family Members: Estimated Statewide Totals

Category	Number (Total FTE)	Percent
Consumers.....	250	28.7%
Family Members.....	76	8.7
Either or Both	545	62.6
Total, statewide.....	871	100.0%

Appendix B lists consumer/family member job titles in 36 county CSS plan summaries, and the manner in which they were classified: for (1) Consumers, (2) Family Members, or (3) Either or Both.

Positions set aside for family members typically contain the term “parent” or “family” in the job title (e.g., Parent Partner, Family Member Provider, Family Advocate, Family Partner, and Family Member Manager). The remaining positions for consumers or family members have titles that are not specifically targeted at consumers and family members. This

category contains the majority of positions. The job titles in this category include: Community Worker, Medical Case Worker, Mental Health Worker III, Family/Peer Partner, Mental Health Worker, and Social Worker. Some managerial and professional positions will be held by consumers or family members, including Director, Executive Director, Program Manager, Psychiatrist, Public Health Nurse, and Registered Nurse. In nearly every case, only one FTE was listed across the 36 counties when jobs such as these were mentioned for consumers and family members.

Service Provider. – Nearly 62 percent of the new positions – or, approximately 2,662 out of 4,332 -- are classed as service provider positions. Table 3 shows the general pattern of these positions, based on assumptions about where job titles seem to fit in an occupational classification scheme. Again, Appendix B shows how various job titles have been categorized.

Table 3. Service Provider Positions, by Category: Estimated Statewide Totals

Category	Number (Total FTE)	Percent
Psychiatry (& general medicine).....	146	5.5%
Nursing	240	9.0
Social work	404	15.2
Psychology	145	5.5
Therapy/counseling	461	17.3
Case management	561	21.1
Mental health worker*	450	16.9
<i>Sub-total</i>	<i>2,407</i>	<i>90.4%</i>
All Other:		
Allied health professionals.....	40	1.5%
Co-occurring disorders	61	2.3
Employment.....	18	0.7
Housing	11	0.4
Police and courts.....	17	0.6
Transportation	2	0.1
Financial and other assistance.....	43	1.6
Miscellaneous (n.e.c.)	64	2.4
	<i>256</i>	<i>9.6%</i>
Total, statewide	2,662	100.0%

* The largest single category, reported by Los Angeles County, was “Community Worker.”

Administrative, Supervisor, Staff support. – About 18 percent of new positions – or, about 799 out of 4,332 – have been categorized as supervisory, management, and support personnel. Table 4, on the next page, shows the pattern of these positions, based on

certain assumptions as to where various job titles belong. Again, Appendix B shows which job titles were put into the various categories.

Table 4. Administrative, Supervisory, and Support Positions, by Category: Estimated Statewide Totals

Occupational category	Number	Percent
Supervisor/Program Manager	251	31.4%
Support Staff:		
Analyst, IT staff.....	43	5.4
Other Office Staff.....	471	58.9
Education, Training and QA/QI	12	1.5
Miscellaneous (n.e.c.)	23	2.8
Total, statewide	799	100.0%

The *Supervisor/Program Manager* category includes job titles such as Managers, Directors, Coordinators, and Team Leader, as well as Supervisors of Programs and Services. Several job titles suggest the incumbent is expected to supervise direct service providers or of clinics (e.g., Unit Supervisor, Clinical Supervisor, Supervising Psychiatric Social Worker, Service Chief, and Supervising Nurse). These supervisor/program manager positions account for nearly a third (31.4 percent) of the broader Administrative, Supervisory, and Support Positions category, but only about 6 percent of the overall 4,332 FTE positions.

The category *Support Staff* has been divided into several subcategories: *Analyst, IT Staff* and two other duty-specific subcategories, and a *Miscellaneous* subcategory. Nearly all of the job titles in the *Analyst, IT Staff* subcategory have the term *Analyst* in the title (e.g., Mental Health Planning Analyst, Research Analyst). An exception is “Information systems/Performance Measurement staff.” The most common job title in the *Other Office Staff* subcategory is “Intermediate Typist Clerk” (148 positions, all of which are in the Los Angeles plan). Across all summarized county plans, approximately 10 positions are to be filled by billing clerks and medical records personnel. Most of the other titles are more general (e.g., Clerk, Staff Assistant, Secretary, Office Assistant, Clerical and other support staff). The *Miscellaneous* subcategory includes the positions of Security Guard, Grant Writer, Public Information Officer, and (non-specific) Support Staff.

Human resource (e.g., civil service) matters

The MHSA, as an organizing paradigm, is meant to transform public mental health services into a wellness- and recovery-oriented system by promoting the following strategies: (1) full-service partnerships; (2) prevention and early intervention; (3) wellness, recovery, and resiliency; (4) use of evidence-based practices; (5) language proficiency and cultural competence; and (6) consumer- and family-driven services. One county official told us that in order to expedite the hiring process, job classifications and descriptions for the new positions are derived from existing ones. Once a good match for qualifications and experience is found, references to wellness and recovery and other unique MHSA requirements are added.

The county official with whom we spoke went on to say that successfully implementing the county's Community Services and Supports Plan will require hiring a number of additional professionals and paraprofessionals. Many new hires will need to have specialized qualifications (e.g., gerontology, non-English language proficiency, individuals with mental health challenges). Unless these new hires are subcontracted through community-based organizations, the hiring process must comply with County personnel policies and procedures. We were told that changing civil service job classifications (e.g., duty statements, qualifications required) is a very lengthy and complicated process, requiring reviews by the County personnel department, legal counsel and, ultimately, the Board of Supervisors.

As a result, we suspect that many consumers and family members in entry-level positions will be hired by community-based organizations under contract with the County rather than by the County itself. Each County will develop contracts specifying (in general terms) what kinds of employees are needed to provide MHSA-funded services and what qualifications those employees ought to have. The flexibility of community-based organizations means that consumers and family members are likely to receive more opportunities to enter the public mental health field through these organizations than they would with the County. However, jobs with contract agencies are likely to be characterized by lower pay, fewer benefits, and greater instability than comparable positions within the County civil service structure.

Racial/ethnic diversity, language proficiency, and cultural competence

Race/ethnicity -- As indicated in Table 5, California's total population (in all 58 counties) is exceedingly diverse in terms of race/ethnicity. The racial/ethnic distribution of the population in the 36 counties for which we have CSS plans is virtually the same as for the total population, differing at the statewide level by no more than 0.7 percentage points for any racial/ethnic group (data not shown here).

Table 5. California Population, by MH Region, and Race/Ethnicity: July 1, 2006

Region	Total	White	Black	Hispanic	Asian/PI	Other*
Bay Area	7,988,965	46.0%	6.6%	24.2%	19.9%	3.3%
Southern	12,562,563	43.4	5.2	39.3	9.4	2.7
Los Angeles	10,208,754	31.2	9.5	46.5	11.0	1.8
Central	5,455,122	47.3	6.1	33.9	8.8	3.8
Superior	1,119,564	77.0	1.6	12.6	2.3	6.4
Statewide, total	37,334,968	42.2%	6.7%	36.4%	11.8%	2.9%

* This category is largely Native American and multi-race.

CSS plan summaries contain information on the percentage distribution of the *current mental health workforce*. Counties varied in what they reported. Some counted (or estimated) only the public, county mental health workforce. Some may have counted contractors as well as county employees. Some counties counted only those employees who deliver Medi-Cal services. Table 6, on the next page, shows the reported data (population-weighted proportions) on *current mental health workforce*, by region, based on the 36 counties for which we have CSS plan summaries. The table displays: (1) the estimated population of the counties as of July 1, 2006; (2) the percentage of the population by race/ethnicity; (3) the percentage of the reported *current mental health workforce*, by race/ethnicity; and (4) the percentage point difference between the two distributions.

Hispanic employees are consistently under-represented. The degree of under-representation ranges from –9.3 percentage points (Bay Area) to –27.5 (Los Angeles). Statewide, Hispanics are under-represented by a weighted average of –17.3 percentage points (emphasis added).⁴ Asian/Pacific Islanders are not consistently under-

⁴ A small part of this difference is likely attributable to the younger average age of Hispanics than the population in general. In 2004, Hispanics made up an estimated 34.8% of California's population, but somewhat less (33.3%) of those of working age (18 through 64). (See DOF, 2006).

or overrepresented. Native American and “other” (typically multi-race) are overrepresented in all regions except for the Superior Region, where they are under-represented by -1.8 percentage points. We suspect that subgroups within the Asian/Pacific Islander and Native American & Other groups are under-represented. For example, several CSS plans state counties’ intentions of reaching out to the *rancheria* communities because among these Native Americans the need for mental health services is high but mental health service usage rates are low.

Table 6. Distribution of the Population and *Current Mental Health Workforce*: 36 Counties in DMH Regions

Region	Population	<i>Current MH Workforce</i>	Percentage Point Difference
Bay Area (Population = 7,303,871)			
White	48.7%	52.2%	3.5
Black.....	4.3%	9.6	5.3
Hispanic	25.2%	15.9%	-9.3
Asian/Pacific Islander.....	18.8%	16.1	-2.7
Native American & Other	3.0%	6.2	3.2
Southern (Population = ~9.1 million)*			
White	47.1%	57.4%	10.3
Black.....	4.4%	9.7%	5.3
Hispanic	35.7%	20.1%	-15.6
Asian/Pacific Islander.....	10.1%	5.2%	-4.9
Native American & Other	2.7%	7.6%	4.9
Los Angeles (Population = 10,208,754)			
White	31.2%	42.0%	10.8
Black.....	9.5%	20.0%	10.5
Hispanic	46.5%	19.0%	-27.5
Asian/Pacific Islander.....	11.0%	12.0%	1.0
Native American & Other	1.8%	6.5%	4.7
Central (Population = 3,319,775)*			
White	51.5%	58.0%	6.5
Black.....	5.9%	9.7%	3.8
Hispanic	29.6%	19.5%	-10.1
Asian/Pacific Islander.....	9.0%	6.5%	-2.5
Native American & Other	4.0%	6.4%	2.4
Superior (Population = 799,299)			
White	75.8%	84.7%	8.9
Black.....	1.4%	1.9	0.5
Hispanic	12.8%	3.4	-9.4
Asian/Pacific Islander.....	2.0%	3.8	1.8
Native American & Other	8.0%	6.2	-1.8

* Information missing for one county. Hence, approximate population given.

** Excludes Placer County, which provided no race/ethnicity data for their current mental health workforce.

Threshold languages -- Counties vary enormously in population size, from Alpine, with an estimated 1,344 residents to Los Angeles with a population of approximately 10,208,754. In an Informational Notice,⁵ DMH defined a *threshold language* to mean “. . . a language that has been identified as the primary language, as indicated on the Medi-Cal Eligibility Data System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area, Per Title 9,CCR, Section 1810.410 (f) (3).”⁶

Eight counties (or 14 percent) of California’s 58 counties have no *threshold language* other than English. Thirty-eight counties (or 66 percent) have only Spanish as their *threshold language*. Six counties (or 10 percent) have two *threshold languages*, (1) Spanish and Hmong (Butte, Fresno, Merced); (2) Spanish and Vietnamese (Orange), (3) Spanish and Cambodian (San Joaquin); and (4) Spanish and Russian (Yolo). Six counties, with 50.5 percent of the population as of July 1, 2006, had four or more *threshold languages*. (See Table 7.)

Table 7. California counties with four or more *threshold languages*, by primary non-English language (Y=Yes)

Threshold language*	Alameda	Los Angeles ^a	Sacramento	San Diego	San Francisco	Santa Clara
Spanish.....	Y	Y	Y	Y	Y	Y
Vietnamese.....	Y	Y	Y	Y	Y	Y
Cantonese	Y	Y	Y		Y	
Armenian		Y				
Russian.....		Y	Y		Y	
Hmong.....			Y			
Tagalog.....		Y		Y		Y
Mandarin.....		Y				Y
Cambodian		Y				
Korean		Y				
Farsi.....	Y	Y				
Arabic.....		Y		Y		

* Top twelve non-English primary languages used by Californians.

^a “Other Chinese” is a threshold language in Los Angeles County, but is not a language among the top twelve statewide.

⁵ Informational Notices typically explain existing contractual language and thus become part of DMH’s contract with Counties.

⁶ Source: <http://www.dmh.cahwnet.gov/DMHDocs/docs/notices06/06-04.pdf>

Table 8, below, shows the pattern of threshold languages, other than English, by DMH region. Los Angeles stands out in terms of number of threshold languages. Only the Central and Superior regions have counties with no threshold languages, other than English.

Table 8. Number of Counties with non-English *threshold languages*, by DMH Region

Region	No. of counties (N)	No. of counties with number of threshold languages				
		None (0)	One (1)	Two (2)	Three (3)	Four or more (4+)
Bay Area	12	0	9	0	0	3
Southern	9	0	7	1	0	1
Los Angeles	1	0	0	0	0	1
Central	19	2	12	4	0	1
Superior	17	6	10	1	0	0
Total, statewide	58	8	38	6	0	6

Clearly, many counties face formidable communication barriers when serving various ethnic minorities. This communication difficulty impacts counties' ability to provide culturally competent mental health services. We turn to this subject now.

Workforce needs and challenges

Counties were asked to describe *workforce needs and challenges*. Several *themes* emerged from their responses and are summarized below:

1. **LANGUAGE PROFICIENCY, CULTURAL COMPETENCY, AND REPRESENTATIVE DIVERSITY.** – A major challenge expressed in CSS plans is (1) hiring and retaining sufficient staff who are proficient in non-English languages; (2) being able to deliver culturally-competent services; and (2) having a workforce that reflects the diversity of the underlying population in terms of race/ethnicity.
2. **ORGANIZATIONAL DEVELOPMENT AND TRAINING.** – Another challenge is changing the way public mental health services are provided. Several sub-themes include (1) redesign of services to focus on wellness and recovery, using evidence-based practices, and being consumer- and family-driven; (2) training and supporting the workforce to work in new ways; and (3) surmounting organizational barriers within the system that sometimes get in the way of fashioning new job descriptions, recruiting, and contracting appropriately.
3. **LOCAL DIFFICULTIES IN ATTRACTING AND RETAINING STAFF.** -- Dealing with local, geographic and organizational factors that make attracting and retaining the right people difficult. There include comparatively low wages and benefits, high cost of

living (especially housing), and having “small pools” of potential employees from which to recruit.

4. **INTEGRATING CONSUMERS AND FAMILY MEMBERS INTO THE WORKFORCE.** -- The challenge is hiring and using effectively the services of consumers and family members. Illustrative challenges include: (1) the County mental health system has little or no experience using people with consumer and family member experience; (2) civil service rules, regulations, and practices do not easily lend themselves to altering hiring processes; (3) altering the philosophy (or traditions) of some existing mental health staff to honor MHSA purposes; and (4) being able to find the right consumers and family members to employ effectively.
5. **RECRUITING AND RETAINING LICENSED STAFF.** -- Characteristic challenges include: (1) shortages of licensed professionals; (2) licensed professionals are not always proficient in threshold languages; and (3) many rural areas are disadvantaged when competing with urban areas for licensed staff.
6. **MISCELLANEOUS, OTHER CHALLENGES.** – This is a residual, not elsewhere specified (n.e.s.) category.

Each of the counties for which we have CSS plan summaries noted at least one of the above challenges. Because some comments fell into more than one topical area, there is some repetition. (See Table 9.) Themes above are ranked from (1) *mentioned most often overall* to (6) *mentioned least often overall*. Counter to the overall rank order, counties in the Superior Region ranked Theme No. 2 (Organizational development and training) higher than Theme No. 1 (Language proficiency, cultural competence, and representative diversity). And, counties in the Southern region mentioned No. 3 and No. 4 more frequently than No. 2.

Table 9. County Analysis of Workforce Needs and Challenges: 36 Counties

Region & county	No. of Remark/ topic touches	Topics*					
		No. 1	No. 2	No. 3	No. 4	No. 5	No. 6
Bay Area	42	21	9	7	4	1	0
Southern	33	10	5	8	6	4	0
Los Angeles	5	3	1	0	0	1	0
Central	53	16	14	13	6	3	1
Superior	52	9	16	13	7	2	5
Total, statewide.....	185	59	45	41	23	11	6

* Numbered topics are:

1. Language proficiency, cultural competence, and representative diversity
2. Organizational development and training
3. Local difficulties in attracting and retaining staff
4. Integrating consumers and family members into the workforce
5. Recruiting and retaining *licensed* staff.
6. Miscellaneous, other challenges (n.e.s.)

The comments below were chosen as illustrative of the major themes listed above. All remarks submitted by the counties are listed in Appendix C.

1. LANGUAGE PROFICIENCY, CULTURAL COMPETENCE, AND REPRESENTATIVE DIVERSITY (N = 59)

- _____ County sees the biggest barrier to implementing the MHSA plan is *finding and hiring culturally appropriate staff* with the right training and experience to fill the jobs available.
- *Hispanic staff members* are substantially underrepresented.
- Availability of *culturally and linguistically competent service providers* in _____ County is a challenge. It has been difficult for _____ County to recruit culturally and linguistically competent staff that reflect the ethnic and cultural makeup of our community, particularly Spanish-speaking and Vietnamese-speaking professionals. Competitive salaries for bicultural/bilingual professionals in surrounding agencies and markets, combined with a high cost of living and an inflated housing market further compound this hiring challenge.
- There is a shortage of *bicultural, Spanish speaking clinicians* in every region of the county.
- A potential barrier in implementing the program and decreasing ethnic disparity in access to care/service delivery across all programs will be *hiring staff that are ethnically diverse and proficient in the Spanish language*.
- _____ County has *insufficient Spanish, Vietnamese, Tagalog, Mandarin and Cantonese-speaking staff*.

2. ORGANIZATIONAL DEVELOPMENT AND TRAINING (N = 45)

- *County regulations governing the hiring of staff and entering into contracts* with county providers may present substantial barriers in hiring the workforce needed to implement the vision of the Act.
- Acquiring new facilities, hiring new staff, and issuing new contracts will *challenge the current administrative infrastructure* of the County.
- Training in the *recovery model* may also be a barrier to MHSA implementation. Some of the staff have worked in the mental health field for many years and deliver traditional mental health clinic model services. Training and supervision will assist staff in embracing this system transformation and exploring alternative strategies for meeting the needs of the individual.
- Set of organizational or structural barriers, including (1) the county system does not promote ethnic diversity; (2) certification process for bilingual staff is too rigid; (3) job classifications are not reflective of actual requirements; and (4) overwhelming case loads.

- Transforming the programs to be more *culturally competent, consumer-driven, and family-driven* will require learning and change on the part of existing staff.

3. LOCAL DIFFICULTIES IN ATTRACTING AND RETAINING STAFF (N = 41)

- Recruitment and hiring has been extremely challenging in _____ County due to *staff shortages in human resources, non-competitive wages, and the lack of ethnically diverse individuals in the community.*
- *Serving impoverished individuals in rural and remote areas of _____ remains a challenge.*
- _____ County is a Mental Health Professional Shortage Area and is *competing with counties whose pay scales are superior and who have more resources and amenities.* On the other hand, _____ County's Shortage Area status is helping it attract employees.
- The two primary challenges in _____ County are *geographic isolation, with many very small population pockets spread out across our 3000 square miles, and a high cost of living making recruitment and retention of staff very difficult.* This is not a geographic area that appeals to many prospective staff people. It is isolated and the *winters are long and difficult.* The *cost of living is high.* Additionally, _____ is at 8,000' elevation. Not everyone can live there. _____ County is, however, a federally designated Health Professional Shortage Area for Mental Health.
- It has been difficult at times to hire staff due to the relatively low wage and the high cost of housing in the County.
- _____ Coounty had difficulty *hiring and retaining bilingual/bicultural position* because it is a *small rural county* away form "big city" cultural services and a university.

4. INTEGRATING CONSUMERS AND FAMILY MEMBERS INTO THE WORKFORCE (N = 23)

- Transforming the programs to be *more culturally competent, consumer-driven, and family driven* will require learning and change for all staff.
- *Employment of consumers* in MHSA programs is also challenging. Finding creative solutions and alternatives to the dilemma consumers face in surrendering their Medi-Cal and SSI benefits when accepting paid employment in an MHSA program, and the risk of their illness relapsing to the point of being unable to work for a lengthy period without the security of their SSI or Medi-Cal benefits.
- The County has had difficulties in hiring clients and family members given the civil service code demands and restrictions.
- The county does not currently have and clients or family members that they are aware of who are trained to lead a group or to manage a program.

5. RECRUITING AND RETAINING LICENSED STAFF (N = 11)

- The new CalSWEC stipend program should encourage Humboldt's MSW students to select mental health as their specialty.
- There is a prominent need for licensed clinical social workers, marriage and family therapists, licensed psychiatric technicians, and mental health registered nurses.

6. MISCELLANEOUS, OTHER CHALLENGES (N = 6)

- Lack of trust and credibility with the communities to be served.

Clearly, many counties face challenges hiring and retaining bilingual, culturally competent personnel in various occupational categories. This is very important because of limited access to (and use of) public mental health services by some minority groups. There are perceived shortages in several occupational classifications, even in urban areas. Rural and semi-rural counties face many problems, including (1) inadequate numbers from which to draw, (2) transportation difficulties, (3) non-competitive wages and benefits, (4) high cost of living (especially housing), and (5) lack of various amenities (e.g., most small counties do not have a college or university from which to draw staff). Other obstacles, in both urban and rural areas, include lack of adequate infrastructure (e.g., understaffed Human Resource offices) and dealing with civil service and subcontracting rules. All will need to be surmounted to accomplish many of the MHSA goals.

One-time funds for workforce development (e.g., education and training)

The CSS plan summaries contain information under the heading “5. County Use of One-Time Funds for Workforce Needs to Implement Programs.” Planned expenditures for physical assets and IT systems (e.g., laptop computers, software, office space, furniture and equipment, and vehicles) is not included here. The information under this heading is summarized in Table 10.

Altogether, 24 of the 36 counties for which we have CSS plan summaries requested nearly \$16 million in one-time funds for “workforce needs to implement programs,” excluding IT, infrastructure, and other physical assets. The numbers in Table 10 are “blown-up” regional and statewide estimates, achieved by using the Extrapolation Factors in Appendix A.

Twelve of the 36 counties did not request one-time funds. This is not surprising, as (1) counties were planning for community services and supports, and (2) county officials knew that, in time, there would be a separate allocation for workforce development.

Table 10. County Proposed Use of One-Time Funds for Workforce Needs to Implement Programs (excluding IT and physical infrastructure outlays): Estimated Statewide Total

Region	Number	Percent
Bay Area	\$2,034,625	
Southern ^a	3,774,852	
Los Angeles	10,000,000	
Central ^b	2,166,866	
Superior.....	630,127	
Statewide total	\$18,606,470	100.0%

^a Kern asked for another \$620,000, not shown here, for video conferencing system for several needs, including “training to outlying areas.”

^b Yolo asked for \$454,975 for “. . . development of consumer housing, leveraging construction costs, and for developing long-term supportive services. Yolo County has identified unoccupied county properties that may be available for capital development.” The author’s split of \$400,000 and \$54,975 is a guesstimate.

Table 10 includes outlays for training, internships, schooling, recruitment, and stipends – that is, education and training (or, workforce development). Some counties mentioned non-specific “staff training” or “staff development.” Other counties mentioned several topics, such as but not limited to: risk assessment, employment, aggression replacement, and co-occurring disorders (e.g., substance abuse). Counties requested funds for the following training to help them re-orient their mental health systems to accord with MHSA recovery- and wellness-focused principles:

- Eight counties requested one-time funds specifically for training in *evidence-based practices and/or wellness, recovery, and resiliency*.
- Six counties proposed spending one-time funds for training or identifying needs in the area of *cultural competency*.
- Several counties proposed training for families of young children, adult consumers, and family members, whether in paid positions or not: _____ (*Incredible Years*), _____ (*stigma reduction*), _____ (*Children’s Integrated Services*), _____ (*Incredible Years*), _____ (*interns and stipends for volunteers*), _____ (*General*), and _____ (*Incredible Years or other parenting program*).

Table 10 also includes one-time outlays for program and organizational development (e.g., getting new programs and services *up and running* and redesigning existing services). These planned outlays typically address recruitment, hiring, redesign, consultants, and the like. Selected examples are listed below:

- _____ County is requesting one-time funds of \$10 million, and intends to use the money as follows:
 - \$2.5 million to develop agreements with several degree-producing schools to provide financial support to students, especially bilingual and multicultural students from under-represented groups, in exchange for a commitment to work for one or more years in areas of critical need in the mental health system. Targets social work, marriage and family therapy and psychology graduate students, students in psychiatric technician programs, and people in bachelor's degree programs who commit to working in the mental health system;
 - \$2.5 million to develop an intensive training and orientation program for people not yet working in the mental health system. This will include a substantial number of people and their families who receive services and are members of underserved populations. The trainings will include the principles of wellness, recovery and resilience, introduction to the mental health system, and experiential learning opportunities; and
 - \$5 million to develop an intensive training and orientation program for people currently working in the mental health system and their partnering organizations. The county will prioritize those individuals who are essential in the first phases of implementation for the community services and supports plan. Training modules will be developed to introduce participants to the principles and values of the Act. The county will recruit people from this group who are willing to sponsor experiential placements and jobs for people who have been newly hired.
- One county proposed spending \$191,667 for consultant services, including but not limited to a clinical/peer consultant.
- Another county proposed spending \$1,573,130 on "training, consultation, and support" for several programs: (1) \$575,000 to implement evidence-based practices and fully implement the Parent Support Program; (2) \$125,000 to implement Transition Age Youth programs; (3) \$545,000 to implement adult programs; (4) \$313,500 to implement several evidence-based practices and diagnostic tools in the Integrated Services for Older Adults program; and (5) \$13,300 for staff training on cultural competence to support Outreach and Engagement.
- _____ County requested one-time funds of \$49,800 to support, on a formula basis, (05/06, 06/07, 07/08) all new (and expanded) programs.
- _____ County was specific about a number of trainings, some of which have already been mentioned. In addition, the county requested " . . . implementation funds equivalent to 6 weeks of service operation in each of its programs." These funds are " . . . also needed for program staff to recruit, hire, and train personnel and will be

used to develop initial program outreach strategies to get this program up and running.” \$40,000 was requested for 70 staff/volunteers (includes training tool kit, travel and lodging to Los Angeles, training fees and technical assistance).

- _____ County proposed spending \$840,000 for (1) training of consumers and family members, staff, and Mental Health Board members, (2) consultation on Telemedicine system, (3) advertising and recruitment for staff, (4) RFP development and (5) services and supplies for proposed new staff members.
- Two counties proposed spending \$150,325 on a variety of trainings, plus \$7,200 for extra consultation and \$44,875 for Employment, Dual Diagnosis, Ethics, and Community Integration.
- _____ County proposed using nearly half a million dollars for its program, called Adults: Wellness Alternatives. Specifically, much of the money would be used to leverage construction costs. Some (\$54,975) would be used to develop long-term supportive services. Only the latter is reflected in Table 10.

References

State of California Department of Mental Health (2005). *Mental Health Services Act, Community Services and Supports: Three-Year Program and Expenditure Plan Requirements, Fiscal Years 2005-06, 2006-07, 2007-08* (Sacramento: DMH, August 1, 2005).

State of California, Department of Finance (2006), *Estimated Race/Ethnic Population with Age and Sex Detail, 2000–2004*. (Sacramento: DOF, April 2006).

Appendix A

Department of Mental Health: *Regions, Counties, and Extrapolation Factors*

Department of Mental Health: *Regions, Counties, and Extrapolation Factors*

The five DMH regions, counties included in each, and three-year CSS budget allocations, are shown in Table A-1.

Table A-1. DMH Regions, Counties and Three-Year CSS Budget Allocations		
DMH Region	Counties <u>with</u> plan summaries	Counties <u>without</u> plan summaries
Bay Area	Alameda (\$33,982,044)* Contra Costa (\$21,929,909) Monterey (\$11,845,508) Napa (\$3,466,475) San Benito (\$2,247,034) San Francisco (\$16,422,104) San Mateo (\$15,312,598) Santa Clara (\$41,225,704) Santa Cruz (\$7,296,626) Sonoma(\$11,407,618)	City of Berkeley (\$769,849) Marin (\$5,266,997)
Southern	Kern (\$21,490,172) Orange (\$78,531,339) Riverside (\$51,458,841) San Diego (78,269,899) San Luis Obispo (\$7,066,595) Santa Barbara (\$11,748,507)	Imperial (\$5,231,892) San Bernardino (\$52,867,664) Ventura (\$20,763,127)
Los Angeles	Los Angeles (\$276,507,471)	
Central	El Dorado (\$4,382,902) Madera (\$4,617,552) Mariposa (\$1,161,548) Merced (\$7,726,201) Mono (\$1,087,642) Placer (\$6,964,051) Sacramento (\$30,553,754) Stanislaus (\$13,091,739) Sutter (\$2,887,240) Tulare (\$12,516,200) Yolo (\$5,604,190) Yuba (\$2,483,532)	Alpine (\$777,239) Amador (\$1,620,685) Calaveras (\$1,858,107) Fresno (\$24,519,372) Inyo (\$1,139,376) Kings (\$4,608,314) San Joaquin (\$17,212,892)
Superior	Butte (\$6,096,586) Glenn (\$1,482,113) Humboldt (\$3,945,936) Lake (\$2,317,245) Mendocino (\$2,825,345) Nevada (\$3,086,785) Shasta (\$5,220,806)	Colusa (\$1,313,978) Del Norte (\$1,449,779) Lassen (\$1,461,789) Modoc (\$981,403) Plumas (\$1,195,729) Sierra (\$828,973) Siskiyou (\$1,794,363) Tehama (\$2,184,215) Trinity (\$1,083,023) Tuolumne (2,115,852)

* Excludes amount set aside for the City of Berkeley, for which we do not have a CSS plan summary.

Extrapolation factors for each region, and for the state, are shown in Table A-2.

Table A-2. DMH Regions, Counties, Three-Year CSS Budget Allocations, and Extrapolation Factors to Get Regional and Statewide Estimates

DMH Region	CSS Budget Allocation, 3 Years		Col. (2) divided by Col. (3)	Extrapolation Factor (reciprocal of No. in Col. (4))
	Counties with plan summaries	All counties		
(1)	(2)	(3)	(4)	(5)
Bay Area.....	\$165,135,620	181,107,517	0.91180986	1.0967199
Southern.....	248,565,353	327,428,036	0.75914499	1.3172714
Los Angeles.....	276,507,471	276,507,471	1.00000000	1.0000000
Central.....	93,076,551	144,812,536	0.64273822	1.5558433
Superior.....	24,974,816	39,383,920	0.63413738	1.5769454
Statewide.....	\$808,259,811	\$969,239,480	0.83391136	1.1991682

Source for budget allocations: http://www.dmh.ca.gov/DMHDocs/docs/Letters06/06_03_Encl-1.pdf

Appendix B

Job Titles and Occupational Classifications

Job Titles and Occupational Classifications

Positions for consumers and family members

Below are all the job titles for positions for Consumers and Family members listed in 36 CSS plan summaries: (In parenthesis are the number of FTEs across the 36 counties.)

CONSUMER	EITHER OR BOTH
Client Coordinator (1-4)	Activities Coordinator (1-4)
Client Services Specialist (5-14)	ADMHS Specialist I (1-4)
Consumer Advocate (15-29)	Artist in Residence (1-4)
Consumer Assistance Worker (5-14)	Assistant Program Manager (1-4)
Consumer Advocate (15-29)	Behavioral Health Aide (5-14)
Consumer Associate (1-4)	Case Manager (5-14)
Consumer Crisis Worker (1-4)	Child Care Worker (5-14)
Consumer Housing Activities Coordinator (1-4)	Clerical and other support staff (5-14)
Consumer Self-Help Coordinator (1-4)	Clerical Support (1-4)
Consumer Vocational Activities Coordinator (1-4)	Client and Family Partners (1-4)
Employment Consultant (1-4)	Clinical Services Associate (1-4)
Employment Coordinator (1-4)	Community Support Worker (1-4)
Employment Specialist (5-14)	Community Worker (50+)
Independent Living Coach (1-4)	Consumer Family Advocate (1-4)
Navigator/Consumer Assistant (1-4)	Consumer/Family Behavioral Health Specialist (1-4)
Other (1-4)	Consumer/Family Counselor (1-4)
Part-Time Consumer Staff (1-4)	Contractor Intern/Trainee (1-4)
Peer Advocate (1-4)	Cultural Diversity Officer (1-4)
Peer Benefits Advocate (1-4)	Director (1-4)
Peer Coach (1-4)	Employment Aide (1-4)
Peer Counseling (5-14)	Employment Specialist (1-4)
Peer Counselor (15-29)	Executive Director (1-4)
Peer Guide (5-14)	Extended Placement Coordinator (1-4)
Peer Housing Counselor (1-4)	Family/Peer Partner (30-49)
Peer Liaison (1-4)	Health Worker (1-4)
Peer Mentor (5-14)	Housing Counselor (1-4)
Peer Outreach/Personal Service Coordinator (1-4)	Housing Specialist (1-4)
Peer Outreach Worker (1-4)	In Own Voice Presenters (1-4)
Peer Specialist (15-29)	Intern Trainee (1-4)
Peer Supervisor (1-4)	Lead Spirit Instructor (1-4)
Peer Support Aide (5-14)	Medical Case Worker (30-49)
Peer to Peer Instructor (1-4)	Mental Health Aide (5-14)
	Mental Health Assistant (5-14)

Peer/Recovery Assistant (5-14) Substance Abuse Counselor (1-4) Training Coordinator Peer (1-4) Vocational Assistant (1-4) Work Study Peer (1-4)	Mental Health Client Specialist (1-4) Mental Health Clinician Paraprofessional (1-4) Mental Health Practitioner (1-4) Mental Health Recovery Specialist Aide (5-14) Mental Health Rehabilitation Specialist (5-14) Mental Health Services Coordinator (5-14) Mental Health Specialist (5-14) Mental Health Worker (15-29) Mental Health Worker II (5-14) Mental Health Worker III (30-49) MFT/CSW (1-4) Office Assistant II (1-4) Office Specialist (5-14) Outreach Specialist (1-4) Peer/Family Advocate (1-4) Probation Officer (1-4) Program Coordinator (1-4) Program Manager (1-4) Psychiatric Social Worker (5-14) Psychiatrist (1-4) Public Health Nurse (1-4) Recovery Assistant (1-4) Recovery Model Specialist (1-4) Registered Nurse (1-4) Residential Counselor (5-14) Senior Mental Health Counselor (1-4) Senior Mental Health Worker (5-14) Senior Office Assistant (1-4) Service Chief I (1-4) Social Worker (15-29) Special Activities Coordinator (1-4) Specialist (5-14) Team Leader (1-4) Training Coordinator (1-4) Transition Age Youth Specialist (1-4) Undecipherable (1-4) Warm Line Coordinator (1-4) Youth Staff (1-4) Warm Line Counselor (1-4) Youth Mentor (1-4)
FAMILY Adult Parent Coordinator (1-4) Family Advocate (5-14) Family Coordinator (1-4) Family Member Manager (5-14) Family Member Provider (5-14) Family Support Counselor (1-4) Family to Family Instructor (1-4) Family Partner (5-14) Parent Partner (15-29)	

Service provider positions

Below are all the job titles for service provider positions, as listed in 36 CSS plan summaries:

<p>PSYCHIATRY (& GENERAL MEDICINE)</p> <ul style="list-style-type: none"> ADMHS - Psychiatric Services (1-4) Community Psychiatrist (1-4) Mental Health Psychiatrist (30-49) Physician (1-4) Physician II SAN (1-4) Physician III (1-4) Physician/Psychiatrist (1-4) Psychiatrist (50-74) Psychiatrist II (1-4) Staff psychiatrist (1-4) <p>NURSING</p> <ul style="list-style-type: none"> Behavioral Health Nurse (1-4) Clinical Nurse Specialist (1-4) Community Mental Health Nurse (1-4) Lead Nurse, RN (1-4) Licensed Vocational Nurse (1-4) Mental Health Nurse (1-4) Mental Health Counselor, Registered Nurse (75-104) Nurse Practitioner (5-14) Psychiatric Nurse (15-29) Psychiatric Nurse Practitioner (1-4) Psychiatric Technician (1-4) Public Health Nurse (1-4) Registered Nurse (30-49) Registered Nurse IV (5-14) Staff Nurse, Part-Time (1-4) Staff Nurse, Senior (1-4) <p>SOCIAL WORK</p> <ul style="list-style-type: none"> Clinical Support Social Worker (1-4) Clinical Social Worker (1-4) CSW II (15-29) Mental Health Social Worker (1-4) Psychiatric Social Worker (200+) Psychiatric Social Worker II (1-4) Psychiatric Social Worker III (1-4) Social Work Intern (1-4) 	<p>MENTAL HEALTH WORKERS</p> <ul style="list-style-type: none"> Aide (1-4) Behavioral Health Aide (1-4) Behavioral Health Specialist (5-14) Behavior Specialist II (30-49) Behavior Specialist III (5-14) Client Services Specialist (1-4) Clinical Peer Consultant (1-4) Clinical Service Technician (1-4) Community Health Technician (1-4) Community Mental Health Worker (1-4) Community Services Assistant (5-14) Community Worker (140-199) Consumer Assistant Specialist (1-4) Mental Health Assistant (1-4) Mental Health Client Specialist (15-29) Mental Health Intern, Part Time (1-4) Mental Health Program Specialist (1-4) Mental Health Rehabilitation Specialist (5-14) Mental Health Specialist (15-29) Mental Health Worker (30-49) Mental Health Worker Aide (5-14) Mental Health Worker I, Bilingual (1-4) Mental Health Worker II (1-4) Mental Health Worker II, Bilingual (1-4) Mental Health Worker III (1-4) Older Adult Mental Health Specialist, Unlicensed (1-4) Outreach Specialist (1-4) Outreach Worker (1-4) Senior Client Support Specialist (1-4) Senior Mental Health Worker (5-14) <p>ALL OTHER</p> <p>Allied health professionals</p> <ul style="list-style-type: none"> Occupational Therapist (1-4) Occupational trainees (1-4) Pharmacist (1-4) Recreation Therapist (1-4)
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<p>Social Worker (30-49)</p> <p>PSYCHOLOGY</p> <p>Clinical Psychologist (50-74)</p> <p>Community Mental Health Psychologist (30-49)</p> <p>Psychologist (5-14)</p> <p>Psychologist Intern (1-4)</p> <p>Senior Clinical Psychologist (1-4)</p> <p>THERAPY/COUNSELING</p> <p>Clinical Lead (5-14)</p> <p>Clinician I/II (1-4)</p> <p>Clinician II/Nurse (1-4)</p> <p>Clinician (1-4)</p> <p>Counselor(1-4)</p> <p>Clinical services (counselors, practitioners, assistants) (5-14)</p> <p>Clinical Therapist II (50-74)</p> <p>Coordinator/Therapist (1-4)</p> <p>Family Support Counselor (1-4)</p> <p>Licensed Clinical Social Worker (1-4)</p> <p>LCSW/MFT (15-29)</p> <p>Licensed Mental Health Professional (1-4)</p> <p>Marriage & Family Counselor (5-14)</p> <p>MFC II (1-4)</p> <p>Mental Health Counselor (30-49)</p> <p>Mental Health Counselor, Licensed (1-4)</p> <p>Mental Health Clinical Specialist, Licensed (5-14)</p> <p>Mental Health Clinician (75-104)</p> <p>Mental Health Clinician II (5-14)</p> <p>Mental Health Clinician Intern (5-14)</p> <p>Mental Health Intern/Trainee (1-4)</p> <p>Mental Health Practitioner (15-29)</p> <p>Mental Health Therapist (15-29)</p> <p>MFCC (1-4)</p> <p>MFT(15-29)</p> <p>MFT Intern (1-4)</p> <p>MFT/CSW (1-4)</p> <p>MFT/CSW II (5-14)</p> <p>Senior Mental Health Specialist (1-4)</p> <p>Senior Program Specialist (1-4)</p> <p>Supervising Mental Health Clinician (1-4)</p> <p>Supervising Mental Health Counselor I (1-4)</p> <p>Therapist (5-14)</p> <p>Therapist-physically disabled (1-4)</p>	<p>Rehabilitation Counselor (15-29)</p> <p>Rehabilitation Therapist (1-4)</p> <p>Co-occurring disorders</p> <p>ADP Specialist (5-14)</p> <p>Alcohol and Drug Counselor (1-4)</p> <p>Alcohol and Drug Senior Specialist (1-4)</p> <p>Co-occurring Disorders Specialist (1-4)</p> <p>Drug and Alcohol Specialist (1-4)</p> <p>Dual Diagnosis Specialist (1-4)</p> <p>Substance Abuse Counselor (15-29)</p> <p>Substance Abuse Specialist (15-29)</p> <p>Employment</p> <p>Employment Specialist (5-14)</p> <p>Intake Vocational Assessment Specialist (1-4)</p> <p>Job Coach (1-4)</p> <p>Job Developer (1-4)</p> <p>Mental Health Vocational Specialist (1-4)</p> <p>SSA Employment and Education Specialist (1-4)</p> <p>Vocational Assistant (1-4)</p> <p>Vocational Counselor (1-4)</p> <p>Vocational Specialist (1-4)</p> <p>Housing</p> <p>Housing Coordinator (1-4)</p> <p>Housing Resource Specialist (1-4)</p> <p>Housing Specialist (5-14)</p> <p>Supportive Housing Specialist (1-4)</p> <p>Police and courts</p> <p>Collocated Staff – Probation (1-4)</p> <p>Deputy Probation Officer (1-4)</p> <p>Forensic Sr. Mental Health Specialist, Licensed (1-4)</p> <p>Law Enforcement Officer (1-4)</p> <p>PERT Law Enforcement Supervisor (1-4)</p> <p>Probation Officer (5-14)</p> <p>Security (1-4)</p> <p>Transportation</p> <p>Transportation Aides (1-4)</p>
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CASE MANAGEMENT

Personal Service Coordinator (30-49)
Case Manager (50-74)
Case Manager II (1-4)
Case Manager/Mental Health Worker (1-4)
Family Service Coordinator (5-14)
Medical Case Worker (140-199)
Mental Health Case Manager II (1-4)
Mental Health Case Worker (5-14)
Mental Health Recovery Specialist (30-49)
Mental Health Services Coordinator (105-139)

Financial and other assistance

Benefit Advocate (1-4)
Collocated Staff – CWS (1-4)
Collocated Staff - Public Health (1-4)
Cultural/Linguistic Consultant (1-4)
Cultural/Linguistic Counselor (1-4)
Eligibility Specialist (1-4)
Eligibility Technician (1-4)
Financial Services Specialist (1-4)
Health Services Rep (15-29)
Patient Financial Services Worker (1-4)
Patient Service Representative (1-4)
Patient Services Assistant (1-4)
Patient Services Specialist (1-4)
Public Health Education Assistant (1-4)
Substitute Payee Specialist (1-4)

Miscellaneous (n.e.c.)

Activity Coordinator (1-4)
Adult Mental Health Advocate (1-4)
Board and Care Counselor (1-4)
Consumer Liaison (1-4)
Facilitator (1-4)
Family Advocate (1-4)
Health Worker (15-29)
ICI (5-14)
Masters Level (1-4)
Mobile Crisis Responder (1-4)
PhD (1-4)
Prevention, Youth Development Specialist
(1-4)
Rehabilitation Coverage Counselor (1-4)
Residential Manager (1-4)

Supervision, program management, and support staff

Below are all the job titles for positions involving management, administration, supervision, and support staff, as listed in 36 CSS plan summaries:

SUPERVISOR/PROGRAM MANAGER	SUPPORT STAFF <i>(continued)</i>
<ul style="list-style-type: none"> Administrative Supervisor Manager (1-4) Administrator (1-4) Adult Behavior Health Supervisor (1-4) Assistant Director (1-4) Assistant Program Director (5-14) Behavioral Health Unit Supervisor (1-4) Chief Psychiatric Social Worker (1-4) Child Behavioral Health Supervisor (1-4) Client Services Supervisor (1-4) Clinical Program Coordinator (1-4) Clinical Services Manager (1-4) Clinical Supervisor (1-4) Coordinator of Mental Health Programs (1-4) Director (1-4) Director of Adult Services (1-4) Executive Director (1-4) Health Care Program Manager (5-14) Health Program Coordinator(1-4) Manager of Mental Health Programs (1-4) Mental Health Clinical District Chief (1-4) Mental Health Clinical Program Head (1-4) Mental Health Manager (1-4) Mental Health Program Coordinator (5-14) Mental Health Program Manager (1-4) Mental Health Services Supervisor B (5-14) Mental Health Team Supervisor (1-4) MHSA Coordinator (1-4) MHSA Support Staff (1-4) Outreach Coordinator (1-4) Primary Care Director (1-4) Program Coordinator (1-4) Program Director (5-14) Program Director Assistant (1-4) Program Manager (15-29) Program Supervisor (1-4) Project Manager (1-4) Psychiatric Social Worker Supervisor (1-4) Senior Program Manager (1-4) 	<ul style="list-style-type: none"> Other Office Staff Administrative Aide (1-4) Administrative Assistant (5-14) Administrative Clerk (5-14) Administrative Specialist (1-4) Administrative Support (5-14) Billing Clerk(1-4) Clerical and other support staff (15-29) Clerk(1-4) Intermediate Typist Clerk (140-199) Medical Assistant (1-4) Medical Billing Technician (1-4) Medical Records Technician (5-14) Medical Services Clerk (1-4) Mental Health Records Technician I (1-4) MRT Liaison (1-4) Office Assistant (5-14) Office Assistant I (1-4) Office Assistant II (15-29) Office Assistant III (1-4) Office Assistant Sr (1-4) Office Manager (1-4) Office Services Specialist (1-4) Office Services Technician (15-29) Office Specialist (1-4) Office Supervisor (1-4) Office Technician (1-4) Patients Account Rep (1-4) Program Administrative Staff (15-29) Program Assistant (5-14) Receptionist (5-14) Secretary (1-4) Secretary I (1-4) Senior Office Assistant (1-4) Specialist Clerk (1-4) Staff Assistant (30-49) Supervising Clinic Clerk (1-4)

<p>Service Chief (5-14) Service Chief I (1-4) Service Chief II (1-4) Social Worker Supervisor (1-4) Supervising Clinician (1-4) Supervising Mental Health Clinician (1-4) Supervising Mental Health Psychiatrist (1-4) Supervising Nurse (1-4) Supervising Psychiatric Social Worker (50-74) Team Leader (5-14) Unit Supervisor (5-14) Vocational Manager (1-4)</p> <p>SUPPORT STAFF Analyst, IT staff ADMHS Specialist II (5-14) Administrative Analyst (1-4) Analyst (1-4) Contractor MH (5-14) Department Analyst (1-4) Health Care Analyst (1-4) Human Services Analyst (1-4) Information System Analyst (1-4) Information Systems/Performance Measurement Staff (1-4) Mental Health Analyst (5-14) Mental Health Planning Analyst(1-4) Research Analyst (1-4) Senior Staff Services Analyst (1-4) Staff Services Analyst (1-4)</p>	<p>Education, Training, and QA/QI Compliance Officer (1-4) Quality Assurance Specialist (1-4) Trainer/Volunteer Coordinator (1-4) Training and Education Coordinator (1-4) Training and Quality Management (1-4) Training Coordinator (1-4)</p> <p>Miscellaneous (n.e.c.) C72-05 (1-4) Grant Writer (1-4) Mental Health Worker Aide (1-4) Public Information Officer (1-4) Security Guard (1-4) Service Coordinator (1-4) Stock/Delivery Clerk (1-4) Support Staff (5-14)</p>
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Appendix C

County Analysis of Workforce Needs and Challenges

Themes are numbered in Appendix Table C-1, as follows:

- No. 1. Language proficiency, cultural competence, and representative diversity
- No. 2. Organizational development and training
- No. 3. Local difficulties in attracting and retaining staff
- No. 4. Integrating consumers and family members into the workforce
- No. 5. Recruiting and retaining *licensed* staff.
- No. 6. Miscellaneous, other challenges (n.e.s.)

Table C-1. County Analysis of Workforce Needs and Challenges

Region	Whether touches on Topic* . . . (Y=Yes)					
	No. 1	No. 2	No. 3	No. 4	No. 5	No. 6
Bay Area:						
<ul style="list-style-type: none"> Overall analysis of the assessment plan data point to the fact that the two ethnic groups whom _____ County's mental health system is currently least equipped to serve are Asians and Latinos. The percentage of Asian direct service providers and clients currently served is relatively small in all regions. However, specific data on threshold languages show that there are not enough Vietnamese and Cantonese speaking providers. In addition, the percentage of Asian residents who may need services is either twice or almost twice the percentage of current providers in three of the four regions. To remedy this shortfall, there will need to be an increase in language-specific providers and interpreters. 	Y					
<ul style="list-style-type: none"> Latinos suffer from a lack of culturally and linguistically competent services. Latinos may need services in twice to three times the percentage of direct service provider populations or currently served populations. 	Y					
<ul style="list-style-type: none"> Current data on populations and ethnic composition of persons in need of mental health services will need to be upgraded. While we currently rely on U.S. Census data, there have been challenges regarding rapid population changes not captured in the Census data and 'hidden populations' including Native Americans, Afghans, Persians, Southeast Asians, and undocumented Latinos. These populations are undercounted. 	Y					
<ul style="list-style-type: none"> _____ County sees the biggest barrier to implementing the MHSA plan is finding and hiring culturally appropriate staff with the right training and experience to fill the jobs available. 	Y					
<ul style="list-style-type: none"> Latinos, African Americans and Asian Pacific Islanders are over represented in the _____ County social welfare and justice system, in terms of their proportions in the general population. 	Y					
<ul style="list-style-type: none"> Latinos, particularly Spanish speaking, and Asian/Pacific Islanders are underrepresented in the service providers. 	Y					
<ul style="list-style-type: none"> There is wide disparity between the primarily Latino population and mental health provider staffing. 	Y					

Region	Whether touches on Topic* . . . (Y=Yes)					
	No. 1	No. 2	No. 3	No. 4	No. 5	No. 6
<ul style="list-style-type: none"> It is a challenge to hire bicultural and bilingual staff due to the lack of ethnically diverse candidates available in the workforce. 	Y		Y			
<ul style="list-style-type: none"> Transforming the programs to be more culturally competent, consumer-driven, and family-driven will require learning and change on the part of existing staff. 	Y	Y		Y		
<ul style="list-style-type: none"> The high cost of housing is a challenge in recruiting new staff of any ethnicity. 			Y			
<ul style="list-style-type: none"> Acquiring new facilities, hiring new staff, and issuing new contracts will challenge the current administrative infrastructure of the County. 		Y				
<ul style="list-style-type: none"> All mental health staff/programs are currently located within the City of _____. This is, in itself, a barrier to outreach and engagement of all consumers of service, but particularly Latinos and Asians who live in _____, _____, and _____. 		Y	Y			
<ul style="list-style-type: none"> Further work needs to be done to attract and maintain Hispanic mental health staff both for current as well as MHSA funded services. The lack of diversity in the County's Mental Health staffing is not limited to the Hispanic population. Currently, Mental Health services have one Asian line worker of Chinese heritage who speaks Cantonese and who can understand Mandarin. Also, while the Mental Health caseload currently includes consumers who are African American, there are no African American line staff. 	Y					
<ul style="list-style-type: none"> There is a dire need for training in the recovery model and on cultural competency that if unaddressed could serve as a barrier to MHSA implementation. Some County and contractor staff have worked in the mental health field for many years and deliver traditional mental health clinic model services. 	Y	Y				
<ul style="list-style-type: none"> _____ 's biggest barrier to implementation will be to hire ethnically diverse staff. _____ is located near three larger counties . . . which have substantially higher pay scales. This difference in pay structures creates a barrier to hire qualified, bilingual, bicultural staff and licensed clinical staff. 	Y		Y		Y	
<ul style="list-style-type: none"> Another anticipated barrier is the ability to hire consumers and family members to work with staff to deliver MHSA services. Given the smaller population of the county, there are fewer persons from which to hire staff. Our county is also a 			Y	Y		

Region	Whether touches on Topic* . . . (Y=Yes)					
	No. 1	No. 2	No. 3	No. 4	No. 5	No. 6
bedroom community for . . . where higher paying jobs are available to some of the consumers who have the skills levels and stability to be candidates for employment.						
<ul style="list-style-type: none"> • Training in the recovery model may also be a barrier to MHSA implementation. Some of the staff have worked in the mental health field for many years and deliver traditional mental health clinic model services. Training and supervision will assist staff in embracing this system transformation and exploring alternative strategies for meeting the needs of the individual. 		Y				
<ul style="list-style-type: none"> • _____ has long been a diverse city attracting numerous immigrant groups, and thus the need to provide services to clients of a variety of ethnic backgrounds and language proficiencies is already a priority of the county's public health system. The client population and provider population are already relatively matched ethnically. 	Y					
<ul style="list-style-type: none"> • Further investigation must be done regarding the Department of Public Health's ability to provide culturally and linguistically competent services at all levels of the system. It is not clear whether any consumers entering the system at any level will have immediate access to the providers with whom they have the closest cultural match. 	Y	Y				
<ul style="list-style-type: none"> • Leadership positions in the mental health system are predominantly held by whites. Greater representation by underrepresented groups, especially Latinos and Asians, would increase the system's ability to provide culturally competent services to all clients. 	Y	Y				
<ul style="list-style-type: none"> • The number of providers who can provide services in Spanish is far below the number of clients needing services in that language. 	Y					
<ul style="list-style-type: none"> • _____'s Spanish language capacity within direct services has improved over the years, but further improved capability is needed to meet the needs of this community. 	Y					
<ul style="list-style-type: none"> • _____'s Asian (including Tagalog, Cantonese and Mandarin) and Pacific Islander language capacity within direct services (both County-Operated and Contracted) should be strengthened to mirror the population of the County. 	Y					

Region	Whether touches on Topic* . . . (Y=Yes)					
	No. 1	No. 2	No. 3	No. 4	No. 5	No. 6
<ul style="list-style-type: none"> Overcoming the challenge of meeting the needs of racially, ethnically and linguistically diverse populations has been the focus of multi-year efforts in _____. 	Y					
<ul style="list-style-type: none"> _____ County has insufficient Spanish, Vietnamese, Tagalog, Mandarin and Cantonese-speaking staff. 	Y					
<ul style="list-style-type: none"> The cost of living is higher in _____ County compared to other counties in the region so it may be harder to recruit and retain staff. 			Y			
<ul style="list-style-type: none"> It is challenging to recruit consumer and family staff, particularly from ethnic communities. 				Y		
<ul style="list-style-type: none"> The Spanish language test administered by the county of _____ does not test for the capacity needed to provide specialty mental health services. There are some staff that pass the language test but are unable to provide the services. 		Y				
<ul style="list-style-type: none"> The County has had difficulties in hiring clients and family members given the civil service code demands and restrictions. 		Y		Y		
<ul style="list-style-type: none"> It has been difficult at times to hire staff due to the relatively low wage and the high cost of housing in the County 			Y			
<ul style="list-style-type: none"> Staff lack sufficient language and cultural competence skills. 	Y					
Sub-total (Avg), Bay Area: N	21	9	7	4	1	0
Sub-total (Avg), Bay Area: %	50%	21%	17%	10%	2%	0%
Southern:						
<ul style="list-style-type: none"> _____ CMH needs an adequate number of bilingual/bicultural staff to serve the Hispanic/Latino consumer population. 	Y					
<ul style="list-style-type: none"> Serving impoverished individuals in rural and remote areas of _____ remains a challenge. 			Y			

Region	Whether touches on Topic* . . . (Y=Yes)					
	No. 1	No. 2	No. 3	No. 4	No. 5	No. 6
<ul style="list-style-type: none"> _____ County acknowledges that culturally competent programs and services, in order to effectively reach consumers from any ethnic group, must ensure consumer and family involvement as an essential component for systematic transformation. Consequently, "business as usual" models for engaging consumers of minority groups have not effectively achieved proportionate access to services, and therefore must be improved. 	Y	Y		Y		
<ul style="list-style-type: none"> Availability of culturally and linguistically competent service providers in _____ County is a challenge. It has been difficult for _____ County to recruit culturally and linguistically competent staff that reflect the ethnic and cultural makeup of our community, particularly Spanish-speaking and Vietnamese-speaking professionals. Competitive salaries for bicultural/bilingual professionals in surrounding agencies and markets, combined with a high cost of living and an inflated housing market further compound this hiring challenge 	Y		Y			
<ul style="list-style-type: none"> Employment of consumers in MHSA programs is also challenging. Finding creative solutions and alternatives to the dilemma consumers face in surrendering their Medi-Cal and SSI benefits when accepting paid employment in an MHSA program, and the risk of their illness relapsing to the point of being unable to work for a lengthy period without the security of their SSI or Medi-Cal benefits. 				Y		
<ul style="list-style-type: none"> Hire sufficient staff to provide evidence-based and recovery-based services which are cross-culturally capable, including bilingual/bicultural staff. 	Y	Y				
<ul style="list-style-type: none"> Hire, train and support clients and family members in providing services using recovery/wellness/resiliency models. 		Y		Y		
<ul style="list-style-type: none"> Develop services that are to be provided in rural and poverty-impacted areas and in communities with Spanish-speaking populations where services are under-utilized 	Y		Y			
<ul style="list-style-type: none"> Address and resolve internal administrative barriers to the effective use of Consumer Providers, Parent Partners and Family Advocates. 		Y		Y		
<ul style="list-style-type: none"> Collaborate with other agencies and providers to reduce fragmentation of services, improve integrated services, and target services to create measurable outcomes. 		Y				

Region	Whether touches on Topic* . . . (Y=Yes)					
	No. 1	No. 2	No. 3	No. 4	No. 5	No. 6
<ul style="list-style-type: none"> _____ Mental Health Services has experienced challenges in hiring client and family members. 				Y		
<ul style="list-style-type: none"> _____ Mental Health Services faces difficulty in recruiting and hiring culturally and linguistically diverse staff due to human resource shortages in the field and strong competition for culturally and linguistically diverse professionals and Consumer/Family members. 	Y			Y	Y	
<ul style="list-style-type: none"> The high costs of housing and other costs of living expenses that are higher than other counties makes it even more difficult to hire and retain staff. 			Y			
<ul style="list-style-type: none"> There is a shortage of bicultural, Spanish speaking clinicians in every region of the county. 	Y				Y	
<ul style="list-style-type: none"> There is a lack of Vietnamese clinical staff serving both children and adults. 	Y				Y	
<ul style="list-style-type: none"> _____ County has difficulty in hiring and retaining bilingual and bicultural staff. 	Y					
<ul style="list-style-type: none"> There are three state institutions in the area which offer richer resources to recruit and retain mental health professionals. 			Y			
<ul style="list-style-type: none"> The cost of living and housing costs are high in _____ County. 			Y			
<ul style="list-style-type: none"> Large portions of the Latino population and persons in poverty are located in relatively remote areas that are not readily available to services or transportation. 			Y			
<ul style="list-style-type: none"> A potential barrier in implementing the program and decreasing ethnic disparity in access to care/service delivery across all programs will be hiring staff that are ethnically diverse and proficient in the Spanish language. 	Y					
<ul style="list-style-type: none"> Additional barriers to program implementation involving staffing issues include the recruitment of medical staff such as Registered Nurses, Psychiatric Nurse Practitioners, Physician Assistants and Psychiatrists. These positions have posed challenges due to statewide and nationwide shortages of trained personnel and the high cost of living in _____ County 			Y		Y	

Region	Whether touches on Topic* . . . (Y=Yes)					
	No. 1	No. 2	No. 3	No. 4	No. 5	No. 6
Sub-total (Avg), Southern: N	10	5	8	6	4	0
Sub-total (Avg), Southern: %	30%	15%	24%	18%	12%	0%
<ul style="list-style-type: none"> Hispanic staff members are substantially underrepresented. 	Y					
<ul style="list-style-type: none"> There is an overall need for bilingual staff in many threshold languages, particularly Spanish, Cantonese/Mandarin/Other Chinese, Armenian, Farsi and Korean 	Y					
<ul style="list-style-type: none"> There is a prominent need for licensed clinical social workers, marriage and family therapists, licensed psychiatric technicians, and mental health registered nurses. 					Y	
<ul style="list-style-type: none"> Non-threshold language needs have been increasing, as more monolingual groups have been immigrating to _____ County, including large groups of refugees from Arabic-speaking countries, Bosnia, Kosovo, Ethiopia, Somalia and Senegal. 	Y					
<ul style="list-style-type: none"> County regulations governing the hiring of staff and entering into contracts with county providers may present substantial barriers in hiring the workforce needed to implement the vision of the Act. 		Y				
Sub-total (Avg), Los Angeles: N	3	1	0	0	1	0
Sub-total (Avg), Los Angeles: %	60%	20%	0%	0%	20%	0%
Central:						
<ul style="list-style-type: none"> _____ County has collaborative relationships with community-based service providers who provide bilingual/bicultural human services. Their goal is to build upon these relationships by adding the mental health specialty component and related support services, to create an integrated delivery system. 		Y				
<ul style="list-style-type: none"> The MHSA Project Staff has joined the health care subcommittee of the <i>Adelante</i> Project to be poised to integrate efforts and lessons learning in order to operationalize culturally competent strategies with the Latino community. 	Y					
<ul style="list-style-type: none"> _____ County needs to develop clear standards and an improved practice for 		Y				

Region	Whether touches on Topic* . . . (Y=Yes)					
	No. 1	No. 2	No. 3	No. 4	No. 5	No. 6
certifying bilingual staff and for acquiring translated written materials.						
<ul style="list-style-type: none"> They need to identify successful ways to recruit and hire bilingual/bicultural Latino staff for both regions of the County. 		Y				
<ul style="list-style-type: none"> Recruitment and hiring has been extremely challenging in _____ County due to staff shortages in human resources, non-competitive wages, and the lack of ethnically diverse individuals in the community 		Y	Y			
<ul style="list-style-type: none"> Employment of consumers and family members has traditionally been on a part-time basis -- primarily at the individuals' preferences due to financial and family issues. 				Y		
<ul style="list-style-type: none"> The process for hiring County staff can be lengthy. 		Y				
<ul style="list-style-type: none"> Salaries for clinicians, case managers, and support staff are considerably lower than the larger counties to the north and south of _____. 			Y			
<ul style="list-style-type: none"> The minimal increase in pay for those who are bilingual does not encourage recruitment or retention of bilingual/bicultural staff. 	Y	Y				
<ul style="list-style-type: none"> The percentage of staff who are Hispanic/Latino is close to the percentage served, but lower than the percentage in the total population, indicating the needs of this population have not been well addressed. 	Y					
<ul style="list-style-type: none"> _____ County is currently working in overcrowded conditions. They have space that could be used upstairs after it is remodeled. However they do not have the funds at this time to remodel the building. 		Y				
<ul style="list-style-type: none"> The Board of Supervisors will not allow any expenditures until the plan is approved and the monies are released. 						Y
<ul style="list-style-type: none"> It is difficult to attract and retain skilled staff to a rural area with a lower than competitive pay scale. 			Y			
<ul style="list-style-type: none"> Hiring consumers will be a challenge due to the consumers concerns about losing 				Y		

Region	Whether touches on Topic* . . . (Y=Yes)					
	No. 1	No. 2	No. 3	No. 4	No. 5	No. 6
their Social Security eligibility and losing the funds to pay for their medications.						
<ul style="list-style-type: none"> The county does not currently have and clients or family members that they are aware of who are trained to lead a group or to manage a program. 				Y		
<ul style="list-style-type: none"> In general, there is a shortage of qualified [people] for positions in the Department, including: psychiatrists, nurses, clinicians, mental health workers, emergency services LVNs or LPTs, alcohol and drug counselors, and front office staff. 					Y	
<ul style="list-style-type: none"> _____ County is designated as a mental health provider shortage area. This allows staff members to apply to the National Health Service Corps (NHSC) for student loan repayment assistance 			Y			
<ul style="list-style-type: none"> The highest priority target ethnic population to be served in _____ County through the Mental Health Services Act is Hispanic, which has remained underserved/unserved because of cultural barriers and access problems. 	Y					
<ul style="list-style-type: none"> For the Southeast Asian population, the Mental Health Department utilizes direct oral communication since many refugees from Laos and Cambodia do not read the Hmong language. The Department will work with staff members to educate them about the cultural engagement issues that are unique to the Southeast Asian population. 	Y					
<ul style="list-style-type: none"> The two primary challenges in _____ County are geographic isolation, with many very small population pockets spread out across our 3000 square miles, and a high cost of living making recruitment and retention of staff very difficult. This is not a geographic area that appeals to many prospective staff people. It is isolated and the winters are long and difficult. The cost of living is high. Additionally, _____ [a body of water] is at 8,000' elevation. Not everyone can live there. _____ County is, however, a federally designated Health Professional Shortage Area for Mental Health. 			Y			
<ul style="list-style-type: none"> To send staff from _____ to one of the outlying areas to provide services means, in essence, that the staff person spends three hours on the road and five hours providing services. During the winter months, those figures might be transposed. 			Y			

Region	Whether touches on Topic* . . . (Y=Yes)					
	No. 1	No. 2	No. 3	No. 4	No. 5	No. 6
<ul style="list-style-type: none"> One area of cultural competency that _____ County is continually striving to improve is that of consumer culture and consumer family member culture. 				Y		
<ul style="list-style-type: none"> Difficulties in hiring bilingual/bicultural staff. Overall staff recruitment is hampered by the very high cost of living in _____ County. 	Y		Y			
<ul style="list-style-type: none"> The relative lack of diversity in the county also makes it hard to attract bilingual/bicultural staff. 	Y		Y			
<ul style="list-style-type: none"> The isolation and climate of the Tahoe area also restrict recruitment. In addition, to the very high housing costs, many perspective employees do not want to live in the snow, or face icy (or closed) routes to meetings in _____ or _____. 			Y			
<ul style="list-style-type: none"> The Challenge of recruiting and retaining culturally and linguistically competent staff requires on-going efforts. 	Y					
<ul style="list-style-type: none"> Building and maintaining trusting relationships with cultural and ethnic communities is an on-going challenge. 	Y					
<ul style="list-style-type: none"> Behavioral Health and Recovery Services (BHRS) Latino staff are underrepresented. 	Y					
<ul style="list-style-type: none"> Twenty-nine percent of BHRS staff are bilingual. Thirty-two percent of individuals in _____ County have a primary language other than English. 	Y					
<ul style="list-style-type: none"> Maintaining Spanish speaking direct service staff has proven to be the greatest challenge in this area. Currently only 19% of the direct service staff are Spanish speaking. 	Y	Y				
<ul style="list-style-type: none"> Training the additional staff and partnership organization's staff on recovery/resiliency, cultural competency principles, computer and information system, form completion, workplace safety issues and other training subjects will be a challenge. 	Y	Y				
<ul style="list-style-type: none"> _____ had difficulty hiring and retaining bilingual/bicultural position because it is a small rural county away from "big city" cultural services and a university. 	Y		Y			

Region	Whether touches on Topic* . . . (Y=Yes)					
	No. 1	No. 2	No. 3	No. 4	No. 5	No. 6
<ul style="list-style-type: none"> _____ has a limited experience in working with parent partners. 		Y		Y		
<ul style="list-style-type: none"> [Hard to hire and retain minority and bi-lingual staff] because of lack of monetary incentives; rural setting; low income; insufficient/poor medical and dental benefits; and lack of promotional opportunities. NOTE: Bilingual medical doctors difficult to recruit. 	Y	Y	Y		Y	
<ul style="list-style-type: none"> Set of organizational or structural barriers, including (1) the county system does not promote ethnic diversity; (2) certification process for bilingual staff is too rigid; (3) job classifications are not reflective of actual requirements; and (4) overwhelming case loads. 		Y				
<ul style="list-style-type: none"> Hiring ethnically diverse staff. _____ is located near two larger counties . . . which have substantially higher pay scales. This difference in pay structures creates a barrier to hiring qualified, bilingual, bicultural staff and licensed staff. 	Y		Y		Y	
<ul style="list-style-type: none"> Hiring consumers and family members. Given _____'s small population, there are fewer persons from which to hire staff 			Y	Y		
<ul style="list-style-type: none"> Training in the recovery model. Some _____ staff have worked in the mental health field for many years and deliver mental health clinic model services. Training and supervision will assist staff in embracing system transformation and exploring alternative strategies for meeting individuals' needs. 		Y				
<ul style="list-style-type: none"> _____ 's Children's System of Care provided an excellent model for developing collaborative relationships with allied agencies. A similar system model will be developed for enhancing multiple agency collaboration for the Adult and Older Adult Systems. 		Y				
Sub-total (Avg), Central: N	16	14	13	6	3	1
Sub-total (Avg), Central: %	30%	26%	25%	11%	6%	2%
Superior:						
<ul style="list-style-type: none"> The most challenging area will be human resources. Staffing of county programs is always time-consuming due to the required adherence to personnel processes in 		Y				

Region	Whether touches on Topic* . . . (Y=Yes)					
	No. 1	No. 2	No. 3	No. 4	No. 5	No. 6
place for hiring. _____ County Department of Behavioral Health has a long history of funding positions through grants and other fluctuating sources, hence creating an ongoing familiarity with the personnel system and proactive methods of predicting and responding to the necessary requirements. A good relationship with the Personnel Department assists in meeting this challenge.						
<ul style="list-style-type: none"> The challenge in reducing ethnic disparities is present in the fact that, typically, the pool of applicants is not ethnically diverse and proficient in Spanish and Hmong. In all programs it will be difficult to find staff with these qualifications. 	Y		Y			
<ul style="list-style-type: none"> _____ County has a difficult time training and retaining culturally diverse staff. They are located near three counties that have substantially higher pay scales than they do. 	Y		Y			
<ul style="list-style-type: none"> Transforming the programs to be more culturally competent, consumer-driven, and family driven will require learning and change for all staff. 	Y	Y		Y		
<ul style="list-style-type: none"> Another anticipated barrier is the ability to hire consumers and family members to work with staff to deliver MHSA services. Given the small population of the county there are fewer persons from which to hire staff. 			Y	Y		
<ul style="list-style-type: none"> Difficulty in hiring staff due to human resource shortages, lack of culturally diverse staff, lack of decentralized services, few community providers, and organizations to partner with, lack of training opportunities, and difficulties in hiring consumers and family members. 		Y		Y		
<ul style="list-style-type: none"> In partnership with the State Department of Health and Human Services and _____ State University, a Master of Social Work program has been established that will produce a pool of MSW graduates beginning in FY 2006/07. 		Y			Y	
<ul style="list-style-type: none"> The new CalSWEC stipend program should encourage _____'s MSW students to select mental health as their specialty. 		Y			Y	
<ul style="list-style-type: none"> To resolve the difficulties in hiring consumers and family members, _____ has developed a new Mental Health Aide position that will allow client experience as a hiring factor and a client volunteer network that provides training and experience for 				Y		

Region	Whether touches on Topic* . . . (Y=Yes)					
	No. 1	No. 2	No. 3	No. 4	No. 5	No. 6
consumers.						
<ul style="list-style-type: none"> • Training regarding cultural competence and person-centered treatment planning has not been adequately addressed. 	Y	Y				
<ul style="list-style-type: none"> • The pool of qualified bilingual, multicultural direct services providers is too small to meet the need. 	Y		Y			
<ul style="list-style-type: none"> • The need for ongoing, in-depth training of _____ County Mental Health and partners' staff in culturally competent service delivery approaches. 	Y	Y				
<ul style="list-style-type: none"> • Lack of trust and credibility with the communities to be served. 						Y
<ul style="list-style-type: none"> • _____ County is a Mental Health Professional Shortage Area and is competing with counties whose pay scales are superior and who have more resources and amenities. On the other hand, _____ County's Shortage Area status is helping it attract employees 			Y			
<ul style="list-style-type: none"> • Access is an ongoing problem due to the County's geography, roads, and lack of convenient, affordable transportation. 			Y			
<ul style="list-style-type: none"> • Building and retaining a culturally and linguistically diverse and competent workforce. _____ County Mental Health Department anticipates that recruiting bicultural/bilingual staff to fill MHSA positions will be challenging due to the scarcity of qualified applicants. This challenge is exacerbated by the lack of four-year colleges in the county and the high cost of housing relative to the prevailing wages 	Y		Y			
<ul style="list-style-type: none"> • Serving residents of remote rural communities. Service delivery in _____ County is challenged by geographical barriers--the county's inland and coastal roads connect communities in good weather, but are often closed in winter by mudslides and falling trees. In all outlying areas public transportation is minimal, if it exists at all. Service providers also confront an independent rural mindset that sometimes distrusts government services. This is especially true for many individuals involved in the production or cultivation of illegal substances who fear any type of government activity. 			Y			Y

Region	Whether touches on Topic* . . . (Y=Yes)					
	No. 1	No. 2	No. 3	No. 4	No. 5	No. 6
<ul style="list-style-type: none"> Embedding the principles of recovery and resiliency in all components of the mental health care system. Resolution of this challenge will be an on-going process that utilizes training, community education, and demonstrations of success to overcome bias among some traditional mental health providers who may believe that they know what is best, don't involve consumers in their own recovery, or haven't experienced the benefits of this approach. 		Y				
<ul style="list-style-type: none"> Remaining true to system transformation and community involvement. 		Y				
<ul style="list-style-type: none"> Development of client-run network infrastructure. Acquiring new facilities, recruiting and hiring new staff, issuing new contracts, and incorporating new positions into organizational cultures may challenge the human and physical infrastructure of _____ County Mental Health Department's partners. 		Y		Y		
<ul style="list-style-type: none"> Program monitoring and program improvement 		Y				
<ul style="list-style-type: none"> Human resources with the relevant experience and ethnic diversity in a rural setting are difficult to locate and maintain. Bordering counties . . . all pay higher salaries. _____ County has at times been referred to as a "training" county whose trained staff take higher-paying positions in surrounding counties. Another ongoing issue with staff retention is the absence of affordable housing. 	Y		Y			
<ul style="list-style-type: none"> Another possible barrier is the process of change itself. Behavioral health staff, teachers, administrators, law enforcement, and the community at large need to change the culture of mental health care. Educating these groups in recovery/wellness/ resiliency will be an ongoing task. 		Y				
<ul style="list-style-type: none"> Distance represents another possible barrier. _____ County is a physically large rural county. Traveling between _____ in the east, _____/_____ in the west, and other outlying areas such as _____ requires time and is often difficult due to weather issues. 			Y			
<ul style="list-style-type: none"> _____ department's outreach and engagement to the rural communities will be challenged by the lack of local staff with the expertise to provide the required services. 		Y	Y			

Region	Whether touches on Topic* . . . (Y=Yes)					
	No. 1	No. 2	No. 3	No. 4	No. 5	No. 6
<ul style="list-style-type: none"> The department will also need to work to gain the trust of the rural community and earn the credibility necessary so that _____ County Mental Health and its services are seen as valuable. 						Y
<ul style="list-style-type: none"> The department will also need to overcome the technology and training issues related to providing telepsychiatry services. 		Y				
<ul style="list-style-type: none"> Transportation and access to services will continue to be a challenge in _____ County. 			Y			
<ul style="list-style-type: none"> Income levels for clients and family members continue to be a challenge especially since there has been no significant increase in SSI benefits for some time, and _____ County has high unemployment and CalWORKs caseload reductions. 				Y		
<ul style="list-style-type: none"> The lack of local services other than the Community Mental Health System, the lack of affordable services for those without public benefits, the stigma related to mental illness and the resistance of some to seek treatment also present barriers for clients. 						Y
<ul style="list-style-type: none"> The department will also experience the same challenges as other similar rural counties. Difficulty in hiring ethnically diverse staff, lack of an ethnically diverse population in the County to draw staff from and the difficulty in hiring clients and family members and effectively supporting their employment. 	Y		Y	Y		
<ul style="list-style-type: none"> Staff will need to be retrained in their new roles and become proficient in the recovery, wellness and resiliency philosophy and some will resist the move away from more traditional therapies and philosophies. 		Y				
<ul style="list-style-type: none"> _____ County also has a significant problem with alcohol and drug usage. 						Y
<ul style="list-style-type: none"> _____ County mental health department also needs to increase its collaboration with local hospitals, health clinics and primary care physicians. 		Y				
Sub-total (Avg), Superior: N	9	16	13	7	2	5
Sub-total (Avg), Superior: %	17%	31%	25%	13%	4%	10%

Region	Whether touches on Topic* . . . (Y=Yes)					
	No. 1	No. 2	No. 3	No. 4	No. 5	No. 6
Total, statewide (Avg): N	59	45	41	23	11	6
Total, statewide (Avg): %	32%	24%	22%	12%	6%	3%

* Numbered topics are:

1. Language proficiency, cultural competence, and representative diversity
2. Organizational development and training
3. Local difficulties in attracting and retaining staff
4. Integrating consumers and family members into the workforce
5. Recruiting and retaining *licensed* staff.
6. Miscellaneous, other challenges (n.e.s.)

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AGENDA ITEM III

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MEETING MINUTES - DRAFT

July 27, 2006

Hilton San Diego Airport/Harbor Island
Skyline/Lindberg Room
1960 Harbor Island Drive
San Diego, CA 92101

MEMBERS PRESENT

Gordonna DiGiorgio, Public Member
Robert Gerst, Vice Chair, Public Member
Judy Johnson, LEP Member
Peter Manoleas, Chair, LCSW Member
Karen Pines, MFT Member
Dr. Ian Russ, MFT Member
Victor Law, Public Member

MEMBERS ABSENT

Howard Stein, Public Member

STAFF PRESENT

Paul Riches, Executive Officer
Mona Maggio, Assistant Executive Officer
George Ritter, Legal Counsel
Christy Berger,
Justin Sotelo,
Christina Kitamura, Administrative Assistant

GUEST LIST ON FILE

FULL BOARD OPEN SESSION

The meeting was called to order at approximately 9:12 a.m. Ms. Kitamura called the roll and a quorum was established.

Victor Law arrived at 9:19 a.m. Judy Johnson arrived at 9:40 a.m.

I. CHAIRPERSON'S REPORT

A. Discussion of Letter from the California Association of Marriage and Family Therapists

Peter Manoleas, Board Chair, reported on a letter from the California Association of Marriage and Family Therapists (CAMFT). Paul Riches, Executive Officer, wrote a point-by-point response to CAMFT. The Board's counsel also wrote a point-by-point legal opinion to CAMFT. Mr. Manoleas offered the authors of the letter an opportunity to address the Board.

Mary Riemersma, Executive Director of CAMFT, reiterated some of the issues mentioned in CAMFT's letter. Ms. Riemersma stated she had an issue with the reorganization of the licensing law and noticed some omissions that came from the legislative counsel. She stated that the omissions were items that CAMFT put into law, issues of reimbursement and clarifying scope of practice. CAMFT objected which resulted in the reorganization legislation being pulled from the bill. Another section of concern to CAMFT is the responsibility statement for licensed clinical social workers (LCSW). Ms. Riemersma stated that CAMFT is concerned to see the Board or more Board staff deciding to set policies, law, or regulation. The Board and staff do not have that authority to set aside regulation and implement a policy that is different from regulation. Ms. Riemersma spoke on the issue of the regulatory hearing to delegate authority to the Executive Officer to compel a psychiatric or physical evaluation. She stated that the law permits the Board the authority to compel a psychiatric/physical evaluation, and that it is too much power delegated to one particular individual.

Mr. Manoleas stated that he does not believe there is evidence that the Board has failed to do its due diligence, which was implied in the letter in terms of considering these issues. He stated that each item of concern has been willfully responded to in an efficient and legal sense, and that there is no basis for believing that Mr. Riches is deceiving and misleading the Board or the public.

Judy Johnson stated she has not heard of any discussion or concerns from the Licensed Educational Psychologist (LEP) population. Ms. Johnson would like the Board and organization to work together and maintain collaborative professionalism.

Janlee Wong, National Association of Social Workers - California Chapter, stated that his organization has not discussed this with CAMFT, so he could not comment on some of the issues. However, he noted that his organization does not object to the delegation of authority to the Executive Officer or the submission of supervisory agreement.

Robert Gerst stated that he looked at the information provided as objectively as possible and questioned staff. Mr. Gerst concluded that Board staff has acted honorably, professionally, responsibly, and openly on all of the issues. The staff has provided relative information to the public and to the associations. In all of its activities and communications, the staff has been accurate and truthful, and based where needed on sound legal advice. The staff has kept the Board and public aware, and has sought Board approval on all appropriate issues. Mr. Gerst stated that he would like to see the lines of communication open between the Board and the organization.

Motion -

MR. GERST MOVED THAT THE BOARD EXPRESS ITS CONFIDENCE IN BOTH THE STAFF AND THE EXECUTIVE OFFICER OF THE BOARD. JOAN WALMSLEY SECONDED.

Discussion –

Dr. Ian Russ stated that the Board staff is extremely responsive and supported the motion.

Victor Law stated that the Board has no hidden agenda against Marriage and Family Therapists (MFT) or the association. Mr. Law stated that in no way is the Board allowing the Executive Officer to abuse his powers. He expressed his desire to work with CAMFT on a friendly basis.

Vote -

THE BOARD CONCURRED ON THE MOTION.

Dr. Russ added that it is not his experience on the Board that Mr. Riches has hidden agendas of power seeking.

Donna DiGiorgio stated that there are no hidden agendas and that the Board is here to serve in whatever way possible. She indicated that she would like better communication between the Board and the organization.

Ms. Johnson asserted that she would like to be able to move forward and promote the best professional integrity possible from this point in a collaborative spirit of trust for the consumers and the people who are represented.

Ms. Riemersma stated that her organization has some concerns with the licensing law. She also wants to communicate and work collaboratively with the Board and staff, and move forward. This was an effort to make the Board members aware of the fact that there are concerns, and she is willing to work with the Board to make certain that those concerns are addressed.

B. Report on MHSA Education and Training Advisory Committee Meeting

Mr. Manoleas reported on a meeting that he and Ms. Maggio attended on the Mental Health Services Act (MHSA), Education and Training Advisory Committee in Sacramento on the July 19th. At the meeting, a report was given by Warren Hayes who is the Chief of that section of the MHSA. Mr. Hayes gave an update on their planning process and reports received from the various workgroups.

Mr. Manoleas stated that the MHSA mandated a very thorough planning process for the service and training portion of it. The MHSA and the processes have emphasized consumer involvement, the recovery model, and cultural competence on all levels. Notably absent from this dialogue was the notion of consumer protection

Mr. Hayes' group received reports from all the counties as they were mandated to do. What they received in those reports was in anticipation of what their workforce needs were going to be county by county. After Mr. Hayes aggregated that information, it appeared that what they are anticipating as a result of this act is about 4,000 new positions across the state in different counties. Nineteen percent (19%) of those positions were to be consumer positions as a result of the MHSA funding. The data indicating how many of those positions were going to be licensees and so forth was not available.

Mr. Manoleas stated that there is a process in which it seems that many counties utilize medical dollars delivered to their funding. The current process in place requires the treatment plans to be signed off by a licensees. However, there is a new certification that the state is looking at which is the Psychiatric Rehabilitation Specialist, whom they would like to give the authority to sign off these treatment

plans. This is something that the professional organizations and we want to watch. This will affect the Board and affect public protection.

Mr. Manoleas reported that the group discussed the issue of the Board's examinations and how the changes brought about by the MHSA would need to somehow be incorporated in the examination processes, or would like to see happen. The group also commented that continuing education requirements ought to embody the intent of the MHSA as well.

Mr. Riches stated that he will be working on the licensing committee as well as a other committees. Mr. Riches will be looking at how this intersects with licensing requirements, certification requirements, from the exam, the license portability, career latter issues, and a wide range of issues that are implicated in trying to supply the workforce in this initiative.

Ms. Berger reported that she attended the distance learning workgroup. This group discussed distance learning. They discussed online resources that consumers can access. They also discussed mental health workers and resources available from instructions on completing forms to advancing their training as a mental health worker.

Mr. Manoleas commented that in terms of the future of this process, he was under the impression that the State would like to see as these workgroups and this advisory committee sunset, and see business conducted in regional partnerships that were formed through this advisory committee.

Olivia Loewy, American Association for Marriage and Family Therapists (AAMFT) – California Division, reported that she attended the technical assistance in training workgroup. This group is looking at ways of providing training and assistance to people who are already in the public system. They have identified the need to train the existing staff, clinicians as well as administrators, who are employed there. Ms. Loewy is also participating in the regional partnerships group. This group is discussing setting models throughout the state that replicate the bay area workforce collaborative and how to get a community and all interested service providers and stake holders involved in that process. Ms. Loewy commented on the Psychiatric Rehabilitation Specialist, stating that is a national certification. The association representing this certification in California is CASRA, California Association for Social Rehabilitation Agencies. The director is Betty Dalquist.

II. EXECUTIVE OFFICER'S REPORT

A. Personnel Update

Mr. Riches reported on personnel updates. Effective June 26, 2006, student assistant Nikki Cotto was promoted to Office Technician on a part-time, intermittent basis. Ms. Cotto will work in the enforcement unit.

Mr. Riches introduced a new staff member, Justin Sotelo. Mr. Sotelo is the administrative analyst and will be working on providing support to the Board and Board's policy work and Committee's policy work.

Lorie Kiley, lead cashier, received a promotion to the Committee of Dental Auxiliaries. Ms. Kiley began working at the Committee of Dental Auxiliaries early

July. Gordon Redoble, cashier, was promoted to Management Services Technician as the lead cashier.

B. Report on MHSA Education and Training Workgroups

This item was discussed under Agenda Item I.B.

C. Enforcement Statistics

The enforcement statistics are ordinarily reported through the Consumer Protection Committee meeting. The Committee was unable to meet; therefore, the statistics are reported through the Executive Officer's report.

Mr. Riches reports that there was a significant increase in consumer complaint volume this year, about a 28% increase. From 2001-2002, there has been a 63% increase in the amount of consumer complaints that the Board has been receiving. The enforcement staff continues to do an outstanding job with considerable workload. The numbers increased in every category this year.

Mr. Gerst and Mr. Law requested further breakdowns within the unlicensed category (cease and desist letters), and types of criminal convictions received and license types involved.

D. Proposed 2007 Board Meeting Dates

The proposed 2007 Board meeting dates were reviewed and discussed. The Board agreed to change the summer meeting date to August 2-3, 2007 and fall meeting date to November 8-9, 2007.

E. Miscellaneous Matters

Mr. Riches did not have any miscellaneous matters to report.

III. Approval of May 18-19, 2006 Board Meeting Minutes

Mr. Gerst noted out a typographical error on page 15, 4th paragraph, 3rd sentence, "protect *he* license" should read "protect *the* license."

KAREN PINES MOVED, VICTOR LAW SECONDED, AND THE BOARD CONCURRED TO APPROVE THE MAY 18-19, 2006 BOARD MEETING MINUTES AS AMENDED.

IV. Report of the Budget and Efficiency Committee

Victor Law, Committee Chair, reported that the Committee met on June 21, 2006 in Sacramento and discussed following items:

A. Report and Possible Action on Establishing Delinquency Fees for Continuing Education Providers

Mr. Law reported that the Committee recommends that the Board pursue a regulation to establish a delinquency process for continuing education providers.

Mr. Riches explained that there is no delinquent fee for expired continuing education provider approvals. Currently, a continuing education provider

approval that has expired is cancelled and a new application must be submitted. Staff research indicated that nearly one-third of the new provider applications were from providers whose approvals had been cancelled by failing to renew on time. A new application process generates a lot of workload. Establishing a delinquent renewal fee for continuing education provider approvals would eliminate a significant number of the new provider applications received each year, and continuing education providers will be able to get their approval numbers re-approved in a more expeditious manner.

Mr. Gerst asked how this was going to be conditioned for those continuing education providers with expired approvals.

Mr. Riches responded that the providers would be required to notify attendees of any course provided with a delinquent or cancelled provider approval. Currently when this happens, the provider submits a list of attendees of any course provided with a cancelled provider approval. The provider contacts those individuals and resolve the situation with the individuals who attended the course. The provider is motivated to resolve the matter by obtaining a new approval number and offering a new, free class or a refund.

When staff discovers, usually through audits, that a licensee took a course from a provider with a cancelled approval number, the licensee is given a reasonable amount of time to make up the units and come into compliance.

ROBERT GERST MOVED, DONNA DIGIORGIO SECONDED, AND THE BOARD CONCURRED TO PURSUE A REGULATION TO ESTABLISH A DELINQUENCY PROCESS FOR CONTINUING EDUCATION PROVIDERS.

B. Report and Possible Action on Revising Fee Statutes and Regulations

Mr. Law reported that the Committee recommends that the Board pursue the proposed statutory and regulatory changes regarding fees, renewals, and inactive licenses.

DONNA DIGIORGIO MOVED, JUDY JOHNSON SECONDED, AND THE BOARD CONCURRED TO PURSUE THE PROPOSED STATUTORY AND REGULATORY CHANGES REGARDING FEES, RENEWALS, AND INACTIVE LICENSES.

C. Continuing Education Credit for Attending Board Meetings

Mr. Law reported that the Committee recommends staff bring a proposal to the July Board meeting for consideration. The Committee recommends that the Board will grant six hours of continuing education to any licensee who attends a full day of Board meetings.

Mr. Manoleas had questions regarding the details that staff would need to address. Mr. Law agreed that some work is involved for the staff, but the benefits outweigh the costs. Most of other boards grant continuing education credit for attendees.

Ms. Riemersma, CAMFT, commented that this is a good idea. She advocated for continuing education credit granted for attending a committee meeting because they are sometimes more intense with more opportunity for dialogue.

Dr. Russ, Ms. Walmsley, and Ms. DiGiorgio expressed that they would like to see continuing education credit granted for attending committee meetings.

Mr. Gerst clarified that the proposal would be amended to include attending committee meetings, and to specify that Board members are not eligible to receive credit.

ROBERT GERST MOVED, JOAN WALMSLEY SECONDED, AND THE BOARD CONCURRED TO ACCEPT THE PROPOSAL AS AMENDED TO INCLUDE ALL COMMITTEE MEETINGS.

D. Strategic Plan Update

Mr. Riches reported that the Legislature approved and the Governor signed the Department of Consumer Affairs (DCA) i-Licensing project. The product will not be completed until late 2008 to early 2009.

E. Budget Update

Mr. Gerst stated that the projected expenditures for the Division of Investigation (DOI) and Attorney General (AG) are less than the budget allotment, but there has been more activity in both cases turned over to investigations and to AG office. He requested clarification of this fact.

Mr. Riches explained that the Board has not spent the AG line item in recent years, and several factors go into that. One factor is the amount the Board pays each year. In the last 1-2 years, there has been an increase. Another factor is the number of hours DOI gives the Board. Another factor is the annual rate increase. It tends to multiply when the line item is under spent.

Mr. Manoleas inquired on the hourly rate for investigations.

Mr. Riches explained that the Board's budget for DOI is premised on what the Board spent on DOI two years ago. That basis is rolled forward as this year's budget amount. The amount that is under spent or over spent is reflected in upcoming year. Therefore, it is "washed out" over the years. The hourly rate fluctuates year to year based on how much they budgeted because DOI takes everything that the Board budgets and divides it by the number of hours they give the Board that year. There's a premised hourly rate that is figured in the budget, but that is not always the actual hourly rate.

F. Quarterly Licensing Statistics

Mr. Riches reported that the average processing time for the last quarter was 8.2 days across all of the programs, which is down from the same period last year by 23.4 days. Mr. Riches commended staff for doing a fantastic job. Staff is still looking at processes and attempting to do better. The next big project is resolving the deficiency rate. Deficiencies range from 40% down to 7%-8%.

V. Report of the Communications Committee

Karen Pines, Committee Chairperson reported that there were no action items. The Committee reviewed:

- The progress on achieving the strategic objectives

- The revisions to the Frequently Asked Questions (FAQ) from students
- The draft handbook for examination candidates
- Charts that define hours needed for MFT and LCSW examination eligibility.

A. Strategic Plan Update

Mr. Riches reported that the Board has executed a contract with BPCubed, a public relations firm in Sacramento. They will be performing a communications audit for the Board. The firm will take everything we do in print, on the website, attend the outreach visits with staff, work with staff on presentations, and work with staff on communicating effectively with the public. BPCubed will attend the Communications Committee meeting in September. Their website address is www.bpcubed.com.

B. Supervision Requirements Chart

Ms. Maggio reported that the Board received comments from individuals regarding the charts with some additions to include. Staff is still working on the charts.

Mr. Riches stated that edits are required on the LCSW Experience chart, under the 1st row, 3rd column. It should read “One additional hour of direct supervisor contact.”

Ms. Riemersma, CAMFT, requested some edits on the MFT Experience chart, under Supervision. The first shaded row should read, “A total minimum of 104 *weeks* of supervision is required.” Also under Supervision, #5 Supervision, One-on-One, Minimum and Maximums column, should read “Minimum 52 *weeks*.” Under the shaded row of Supervision Ratios Required for Clinical Experience, under the Notes column, it should clarify the difference between post-degree persons and interns. Ms. Riemersma also suggested that last sentence on the 2nd page of the chart should only read, “The BBS encourages you to thoroughly read the Statutes and Regulations.”

Ms. Johnson suggested creating a similar chart for Licensed Educational Psychologists (LEP) as a communication tool.

VI. Report of the Policy and Advocacy Committee

A. Review and Possible Action on Draft Regulations Related to Supervisor Qualifications [16CCR1833.3 & 16CCR1870].

Robert Gerst, Committee Chair, reported that the Committee recommends that the Board pursue regulation changes to the sections relating to the qualification of supervisors, which would be that, the supervision equals psychotherapy for purposes of compliance with the regulation and delete the requirement that supervisors average five patient/client contact hours per week.

Dr. Russ explained that comments were received that experienced people practicing ongoing clinical supervision kept them in contact with the clinical issues. There were no concerns in the community that this was going to produce poorly qualified supervisors. It was important for agencies to keep the people that the agencies need, some of which moved on to administrative roles, and that it is not economically feasible for these agencies to be using these people for

online clinical contact. They need to be at the supervisory level and the administrative level.

IAN RUSS MOVED, PETER MANOLEAS SECONDED TO PURSUE THE REGULATION CHANGE. ONE MEMBER OPPOSED. THE REMAINDER OF THE BOARD CONCURRED TO PURSUE THE REGULATION CHANGE RELATED TO SUPERVISOR QUALIFICATIONS.

B. Review and Possible Action on Regulations Regarding Abandonment of Application Files (16CCR1806 & 1833.3).

Ms. Berger explained that if a candidate does not take the exam within certain time frames, their application becomes abandoned. One reason the application is abandoned is because the exam was not taken within one-year from the notification of eligibility. Another reason is because the candidate did not take the exam within one year of failing the exam or within one year of passing the standard written exam to take the clinical vignette exam.

Some of the Board's laws and processes are in conflict. Depending on the candidate situation, it actually could give the candidate 1 ½ year or longer in which to take the exam. The Committee wants to clarify this so that everyone has a one-year period before the application will become abandoned.

IAN RUSS MOVED, JOAN WALMSLEY SECONDED, AND THE BOARD CONCURRED TO PURSUE REGULATIONS REGARDING ABANDONMENT OF APPLICATION FEES.

C. Review and Possible Action on Technical Regulation Cleanup Related to LEP and Board Administration Statutory Changes.

Mr. Gerst reported that the Board is seeking to update the LEP statutes and the Board administration statutes. This proposal is part of Senate Bill 1475, as amended on June 19, 2006. The Board's regulations will require some technical amendments in order to conform to these statutory changes.

The proposed changes pertain to the LEP regulations. Section 1854 requires an amendment to conform to the new statutory changes. Section 1855, Section 1856 subdivision (d), and Section 1857 pertains to outdated grandparenting provisions and is proposed to be deleted. Section 1858 content has been included in section 4989.80 of the proposed statute in its entirety, except for subdivision (b) and (j).

Mr. Gerst recommends not having this regulation. Mr. Riches responded that the direction of the staff would be to pursue legislation to incorporate these two provisions and the statutory section on professional conduct.

DR. IAN RUSS MOVED, KAREN PINES SECONDED, AND THE BOARD CONCURRED TO PURSUE THE STATUTORY CHANGES AS AMENDED.

D. Review and Possible Action on Assembly Bill 525 Related to Child Abuse Reporting.

Mr. Gerst reported that Assembly Bill 525 is related to child abuse reporting and requested a motion in support of the bill.

PETER MANOLEAS MOVED, DONNA DIGIORGIO SECONDED, AND THE BOARD CONCURRED TO SUPPORT ASSEMBLY BILL 525.

E. Regulation Update

Title 16, CCR Section 1886.40, Citation and Fees

The final regulations were filed with the Office of Administrative Law (OAL) on June 27, 2006 for final approval.

Title 16, CCR Section 1803, Delegation of Authority to the Executive Officer

This regulation proposal is pending a regulation hearing scheduled this afternoon.

Title 16, CCR Sections 1833.3 and 1870, Supervisor Qualifications

This item was addressed under agenda item VI.

Title 16, CCR, Technical Cleanup - Licensed Educational Psychologists and Board Administration

This item was addressed under agenda item VI.

Title 16, CCR Sections 1806 and 1833.3, Abandonment of Application Files.

This item was addressed under agenda item VI.

Title 16, CCR, Sections 1816.7 and 1887.7, Delinquency Fees for Continuing Education Providers

This item was addressed under agenda item IV.

F. Legislation Update

Mr. Riches reported that AB 1852, Licensed Mental Health Service Provider Education Program, is at the Senate Appropriations Committee.

Mr. Manoleas inquired on the status of AB 2283, Physicians and Surgeons Cultural Background and Foreign Language Proficiency. Ms. Berger responded that the bill is at the Senate Appropriations Committee.

G. Strategic Plan Update

Mr. Riches reported that staff is working through the suggestions from the conference on diversity issues that was held in April. Staff will bring the information back to committees in September.

Mr. Riches also reported that the demographic survey will be mailed by the end of August.

VII. Report of the MFT Education Committee

Dr. Ian Russ, Committee Chair, reported that there were no action items. The Committee met in Burbank on July 21st.

A discussion took place on what public agencies might require of MFTs and the definition of MFT. Answering these questions require looking at what the MHSA is requiring, and to determine if there is the ability in existing statutes to offer coursework that would fulfill MHSA's requirements. Another item that the Committee will need to

look at is if the MHSA is going to require changes to testing for MFTS in order to work in those agencies.

Mr. Manoleas stated that MHSA cannot require it, however, they can talk to the Board about it.

Dr. Russ indicated that some schools were represented at the meeting. Absent from that discussion were other stakeholders which the Committee will actively pursue. This will be at least an 18-month process because the information needed will not be available until spring.

Dr. Russ invited the Los Angeles and Orange County Consortium, and school representatives whom he knew, and plans to invite more people to participate in the discussion. He needs active input from the MHSA view as this progresses. The Committee is in the beginning stages at this point. The next meeting will take place in October. Dr. Russ stated that this will be more productive if discussion includes a wide sense of community.

Ms. Johnson suggested inviting the Postsecondary Education group, as some of those people may want to be included in the dialogue.

Mr. Manoleas suggested contacting Warren Hayes' office to find out what they already have in place that will contribute to the information needed.

Dr. Russ added that the Committee will review and discuss at the job analysis that will be coming in from the State. There may be issues that may or may not be in the curriculum.

The Board convened at 12:02 p.m. and reconvened at 1:10 p.m.

VIII. PUBLIC HEARING ON PROPOSED AMENDMENT TO REGULATIONS

Regulation subject to proposed amendment:

Title 16, Section 1803, California Code of Regulations (16 C.C.R. § 1803).
Delegation of Authority to the Executive Officer of the Board to Order Mental and Physical Health Examinations

George Ritter, the Board's legal counsel, explained that in February 2006 the Board sent out a 45-day notice to interested members of the public intending to adopt changes to C.C.R. Title 16, Section 1803. In that notice, a hearing was not scheduled, however, interested members of the public can request a hearing. A hearing was requested by CAMFT. The only notice of that hearing was issued in conjunction with the Board's agenda. The statute states that once a hearing has been requested, the state agency shall to the extent practicable provide notice of the time, place and date of the hearing to interested members of the public. A separate notice to that degree was not sent to interested members of the public. The Board had the hearing, verbal and written comments were received. Out of an abundance of caution, the Board scheduled another hearing, which is for today. A notice did go out to interested parties for today's hearing. The problem is that in the meantime the text of the regulation has changed. Legally, the notice that went out in May was for the modifications, a 15-day notice. It does not necessarily cure the issue of the original 45-day notice needed for the May meeting. Mr. Ritter discussed this with a senior attorney at OAL who said it was the Board's call. Not wanting to see the regulation held up by a failure to comply with notice

requirement for the May meeting, Mr. Ritter recommended the Board to send another 45-day notice, hold another hearing in September or October in Sacramento, and bring it before the Board in November to receive approval. The hearing does not need to take place at a Board meeting. Any comments already received would go into the rulemaking record. Mr. Ritter would prefer this option rather than having a possible procedural problem and possibly rejected by OAL.

Mr. Russ asked who needs to be or should be at the hearing. Mr. Ritter responded that it does not need to be at a Board meeting; staff generally runs the hearing. There is no formal decision-making, the purpose is to receive testimony for the record.

DONNA DIGIORGIO MOVED, JUDY JOHNSON SECONDED, AND THE BOARD CONCURRED THAT THE BOARD ISSUE A NEW 45-DAY NOTICE FOR THE DELEGATION OF AUTHORITY, C.C.R. TITLE 16, SECTION 1803.

Mr. Ritter addressed the audience and stated that if anyone in the public wished to speak on this matter may do so.

Mary Riemersma, CAMFT, expressed her appreciation that the Board decided to reschedule the hearing. She emphasized that this is an infrequent occurrence to compel a psychiatric or physical evaluation of a licensee or applicant, and the law clearly permits the Board to do both functions. She urged the Board to allow themselves to perform both functions. This is a great amount of power invested in one individual, and would rather see that power vested in the Board as the law prescribes.

No other comments were brought forth for the record.

CLOSE OF PUBLIC HEARING 1:25 P.M.

IX. Review and Possible Action on Proposed Amendments to 16CCR1803 Regarding Delegation to the Executive Officer

There was no action on this topic due to the rescheduling of the hearing.

X. Election of Officers

The Board needs to select a new Chair and Vice-Chair, as it is likely that Mr. Manoleas will not be reappointed. Per Board policy, in the event that the Chair is unable to fulfill their duties for any reason, the Vice Chair automatically becomes the Chair of the Board. Absent any other action, August 1st, we expect Ian to become Chair of the Board. There needs to be an election for the Vice-Chair at the next Board meeting. Mr. Gerst is pending reappointment. Ms. Pines is leaving the Board and is not eligible for reappointment.

Dr. Russ suggested that Mr. Gerst be appointed as Chair, and stated that he was willing to continue as Vice-Chair. He expressed that as Vice-Chair, he is not prepared to become Chair in the event that Mr. Gerst is not reappointed. Mr. Law stated he would be willing to serve as Vice-Chair.

JOAN WALMSLEY MOVED, JUDY JOHNSON SECONDED, AND THE BOARD CONCURRED TO APPOINT MR. GERST AS BOARD CHAIR.

JOAN WALMSLEY MOVED, VICTOR MANOLEAS SECONDED, AND THE BOARD CONCURRED TO APPOINT MR. LAW AS VICE-CHAIR.

XI. Public Comment for Items Not on the Agenda

Heather Halperin, University of Southern California School of Social Work, asked to go back to an issue on item 5 of the Communications Committee regarding the supervision chart. The chart indicates that a person must have one hour of direct supervision per week. One hour is defined as one hour of individual or two hours of group supervision. Not sure if this means that a person is not required to obtain any individual supervision. It is confusing and should be clarified.

Janlee Wong, NASW, asked whether the public will have an opportunity to speak as things progress, as it seems there is a lot that is going to be taking place in the future. Mr. Riches informed him that the public would have an opportunity to speak on those matters.

Olivia Loewy, AAMFT, requested the same change to the MFT chart that Ms. Halperin requested on the LCSW chart.

Dr. Russ presented a resolution to Karen Pines for her 10-year service to the Board, serving as Chair for two terms and as Vice-Chair for one term. Ms. Pines stated it has been a privilege to serve on the Board and to serve her profession, and thanked the Board for making it enjoyable.

Dr. Russ presented a resolution to Robert Gerst for his 3-year service to the Board, serving as Vice-Chair. Mr. Gerst thanked the Board and complimented the Board members and staff for their excellent work.

Mr. Russ presented a resolution to Peter Manoleas for his 4-year service to the Board, serving as Chair. Mr. Manoleas stated how much he has enjoyed working with the Board.

Mr. Wong, NASW, expressed his appreciation to the outgoing Board members on behalf of NASW's members. He stated that a lot has been accomplished through the leadership of the Board and support of the Board staff.

Mary Riemersma, CAMFT, thanked the outgoing Board members on behalf of CAMFT's members for their service and contributions.

Ms. Loewy, AAMFT, thanked the outgoing Board members on behalf of MFTs nationally, for their service for their contribution to California's leadership. She complimented the responsiveness, accessibility, willingness to include and hear from the public, and having a collaborative relationship.

Marci Siegel, San Diego State University School of Social Work, stated she has been working with the Board for over 30 years, serving as an oral examiner and attending Board meetings. She thanked the outgoing members and the Board in general for their contributions to the profession.

Ms. Halperin, USC School of Social Work, stated that she has been coming to meetings for just over a year and has watched it progress into an exciting and well-functioning Board. She has always felt safe in terms of what the Board is doing for licensing. It has been a pleasure taking part of this.

The meeting adjourned at 1:52 p.m.

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AGENDA ITEM IV

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**State of California
Board of Behavioral Sciences**

Memorandum

To: Board Members

Date: November 3, 2006

From: Paul Riches
Executive Officer

Telephone: (916) 574-7840

Subject: Item IV. - Election of Officers

The Board elected Bob Gerst as Chair and Victor Law as Vice Chair of the Board at the July 27, 2006 meeting. Unfortunately, Mr. Gerst was not appointed to a second term on the Board and Mr. Law became Chair on August 1, 2006 per Board policy (B-05-01, attached for your reference). This policy specifies that the new Chair serves until the next regular election of officers. Per recently enacted legislation (Senate Bill 1475, Chapter 659, Statutes of 2006) the Board will hold its next regular election of officers at its May 2007 Board meeting.

The policy further specifies that when the Vice Chair assumes the office of Chair, nominations for a new Vice Chair shall be taken at the next regularly scheduled Board meeting. Accordingly, the Board should take and act on nominations for Vice Chair at this meeting.

Also attached is a list of Board members and the date on which their terms expire.

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ATTACHMENT

Agenda Item IV

Succession of Officers

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**BOARD OF BEHAVIORAL SCIENCES**

400 R Street, Suite 3150, Sacramento, CA 95814-6240
 Telephone (916) 445-4933
 TDD (916) 322-1700
 Website Address: <http://www.bbs.ca.gov>



SUBJECT: Succession of Officers	POLICY # B-05-1	DATE ADOPTED: February 17, 2005
	SUPERSEDES: N/A	PAGE: 1 OF 1
DISTRIBUTE TO: All Board Members	APPROVED BY:	BOARD OF BEHAVIORAL SCIENCES

The Board of Behavioral Sciences takes its mandate to protect the public with the utmost seriousness. Each member recognizes it is a privilege and an honor to serve as a member of the Board of Behavioral Sciences. It is the policy of the Board to adopt a policy that clearly states the appropriate succession of officers.

SUCCESSION OF OFFICERS:

If for any reason the Chairperson of the Board is unable to continue in his/her role as Chairperson, the Vice-Chairperson shall immediately assume the duties of Chairperson until the next election of officers.

Nominations to fill the position of Vice-Chairperson may be made and voted on at the next scheduled Board Meeting.

BACKGROUND: Business and Professions Code Section 4990.6 states “Not later than the first of March of each calendar year, the board shall elect a chairperson and a vice chairperson from its membership.” The law does not address a sudden or unexpected departure of the Chairperson and the Board requested a policy be in place to address the situation.

IMPLEMENTATION: Effective Immediately

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ATTACHMENT

Agenda Item IV

Appointments Table

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Board of Behavioral Sciences

Board Members	Type	Authority	Date Appointed	Term Expires	Grace Expires
Donna DiGiorgio	Public	Governor	9/19/2005	6/1/2007	8/1/2007
Victor Law -- Chair	Public	Assembly	11/1/2003	6/1/2007	6/1/2008
Howard Stein	Public	Senate	5/28/2003	6/1/2007	6/1/2008
Judy Johnson	LEP	Governor	8/24/2005	6/1/2008	8/1/2008
Joan Walmsley	LCSW	Governor	11/11/2005	6/1/2009	8/1/2009
Ian Russ	MFT	Governor	9/19/2005	6/1/2009	8/1/2009
Karen Roye	Public	Governor	9/7/2006	6/1/2009	8/1/2009
D'Karla Leach	Public	Governor	9/7/2006	6/1/2009	8/1/2009
Victor Perez	Public	Governor	11/3/2006	6/1/2010	8/1/2010
Vacant	LCSW	Governor		6/1/2010	8/1/2010
Vacant	MFT	Governor		6/1/2010	8/1/2010

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AGENDA ITEM V

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**State of California
Board of Behavioral Sciences**

M e m o r a n d u m

To: Board Members **Date:** October 30, 2006
From: Christy Berger **Telephone:** (916) 574-7847
Legislation Analyst
**Subject: Agenda Item V. A. - Invite Association of Social Work Boards (ASWB) to
Discuss National Exam for Clinical Social Workers**

In February 2006, the Board of Behavioral Sciences (Board) received a letter from Roger A. Kryzanek, MSW, LCSW and President of the Association of Social Work Boards (ASWB), formerly known as the American Association of State Social Work Boards (AASSWB). The purpose of Mr. Kryzanek's letter is to ask the Board to consider rejoining the ASWB and to require candidates for clinical social work licensure to take ASWB's national examination.

Background

The Board was a member of ASWB from October 1991 through March 1999, and required the ASWB Clinical level examination, along with a state-constructed oral examination for licensure of clinical social workers. However, around 1998, the Board and the Department of Consumer Affairs, Office of Examination Resources (OER) began having concerns regarding the ASWB examination. These concerns included:

- The practice analysis conducted by ASWB did not include a representative number of licensees in California, just 16 participants.
- The sampling of participants in the practice analysis did not include demographics representative of California's population.
- The pass rate for California's first-time examination participants was very high at 89%.

Based on these concerns, and the results of a new California occupational analysis, the Board determined that there was a need for a state-constructed written examination. The new California written examination was administered beginning in late Spring 1999.

About ASWB

Currently, ASWB is comprised of social work regulatory boards in 49 states, the District of Columbia, the Virgin Islands, and seven Canadian provinces. Presently, California is the only U.S. state that is not a member of ASWB and not participating in its examination program. ASWB contracts with ACT, Inc. to administer its examinations at test centers on or near college campuses, and also for psychometric and other support services.

ASWB last completed a practice analysis in 2003 which included 75 surveys returned by California social workers, for 2.1% of the total responses. ASWB has five examination categories for social work, each consisting of 170 items (including 20 pre-test items). All examinations are administered over a four-hour period and cost the candidate \$175, and are as follows:

- *Associate* – Appropriate for paraprofessional social workers. This level uses the Bachelor's examination with a lower pass point.
- *Bachelors* – Appropriate for those who hold a Bachelor's degree in Social Work.
- *Masters* – Appropriate for those who hold a Master's degree in Social Work (MSW).

- *Advanced Generalist* – Appropriate for those who hold a MSW with a minimum of two years of post-degree experience in non-clinical practice.
- *Clinical* – Appropriate for those who hold an MSW with a minimum of two years of post-degree experience in clinical practice. This would be the examination evaluated for possible use in California for LCSWs.

Issues for Consideration

1. The Board would need to determine if the current ASWB national examination meets the standards of examination development and administration currently used by the Board and OER. This would require an in-depth comparison and analysis of the examinations as well as examination policies and procedures.
2. Participation in the national examination may remove a barrier to portability of licensure for clinical social workers, a growing concern since the enactment of the Mental Health Services Act (MHSA) which is increasing demand for all types of mental health workers.
3. Membership in ASWB would give California a voice and vote in setting national standards for clinical social work licensure.
4. Should the Board invite Mr. Kryzanek to the February 2007 Board meeting to obtain more information and to discuss the invitation to rejoin ASWB?

Attachments

- A. Letter from Roger A. Kryzanek
- B. Letter from Donna DeAngelis
- C. ASWB Examination Outlines
- D. February 4, 1999 Examination Committee Meeting Minutes

ATTACHMENT

Agenda Item V. A.

Letter from Roger A. Kryzanek

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BOARD OF
BEHAVIORAL SCIENCES

2006 FEB 24 AM 11:02

February 17, 2006

Mr. Paul Riches, Executive Officer
California Board of Behavioral Sciences
1625 North Market Boulevard, Suite S-200
Sacramento, California 95834

Dear Mr. Riches:

I am the President of the Association of Social Work Boards (ASWB) a nonprofit organization made up of social work regulatory boards in 49 states, the District of Columbia, the Virgin Islands, and seven Canadian provinces. At the present time California is the only state that is not a member of ASWB and not using our examination program. I am writing to ask that the California Board of Behavioral Sciences consider rejoining ASWB.

The California Board of Behavioral Sciences was a valued member of ASWB from 1991 through March, 1999, and provided a number of social workers who were involved with the examination program and other committees. It is my hope that, once again, all 50 states can stand together to ensure that the regulated practice of social work is based on sound national standards and that all involved in regulation can share information, learn from one another, and promote best practices within the regulatory arena.

The mission of the Association of Social Work Boards is to support social work licensing boards and promote regulation of social workers according to uniform standards in order to protect the public. ASWB develops and administers the licensing examinations used by the jurisdictions to determine whether a social work applicant for licensure has the minimum competence necessary to practice. The examination program is one of the most important services provided to regulatory boards by ASWB. There are five categories of examination: Associate for those who do not hold a formal social work degree; Bachelors for social workers with a baccalaureate degree; Masters for those with Masters of Social Work (MSW) degrees upon graduation; Advanced Generalist for MSWs with two or more years of general social work experience; and Clinical for MSWs with two or more years of clinical social work experience. Last year, ASWB tested over 25,000 candidates for social work licensure.

The ASWB licensing examinations are constructed according to the guidelines of the American Psychological Association, the Joint Commission on Standards for Educational and Psychological Testing, the American Educational Research Association, the National Council on Measurement in Education, and the Equal

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Donna DeAngelis, LICSW, ACSW

Mr. Paul Riches, Executive Officer
February 17, 2006
Page Two

Employment Opportunity Commission, with psychometric guidance from ACT, a national testing company. First, the examination questions are based on knowledge statements developed through a nationwide practice analysis survey in which social workers were asked to identify and rank the tasks they must know how to perform on the first day of their job. The data from this survey are analyzed by social work subject matter experts, who then construct the content outline. The survey sample and respondents statistically reflect the make-up of the profession, as does the composition of the group of subject matter experts who analyze the data. The most recent survey was conducted in 2001 – 2003. The examinations that began being administered on May 17, 2004 contain test content that was determined by the results from the survey information.

The final return rate for the usable surveys delivered in this most recent practice analysis was 42 percent overall, with a return rate of 40 percent of responses specifically for the Clinical examination. California social workers were included in this practice analysis. There were 442 surveys distributed to social workers in California, of which the return was 75 surveys, 17 percent of those sent in California and 2.1 percent of the total responses.

Social workers are trained every year to be item writers, and they are the people who develop the specific examination questions. The items that are written are reviewed by Item Development Consultants who either return them to the writer for changes, or approve them to go on to the Examination Committee for review.

The ASWB Examination Committee has 16 members from social work practice and education who are also diverse by race, ethnicity, culture, gender, and geography. This committee reviews every new item and must reach consensus on each item before it is pretested on the social work examinations. The committee specifically looks for only one correct answer for each item. If the committee cannot come to consensus, the question is either discarded or changed.

Items are pretested before they can be used as scored items. When an item is being pretested, it means that the item appears on the examination, but does not count toward the passing score. An item is approved for use as a scored item only if its statistical performance is acceptable. That means that statistically it performs a valid measure of the test taker's knowledge in a particular content area. The system of pretesting questions protects examination candidates by using only questions that have been proven effective in testing relevant knowledge. The answers to pretest items are never counted toward an examinee's score.

There are several versions of each ASWB examination category given at the same time. The members of the Examination Committee review all the items again on each version of the examination before it goes on-line to the test centers to be administered. The questions on each of these versions are different, but the content that is being tested is the same. Candidates are given a different version of the examination if they must retest.

Mr. Paul Riches, Executive Officer
February 17, 2006
Page Three

You can see from the work and care that goes into developing, monitoring, and maintaining the ASWB examination program, that we do not take this responsibility lightly. We perform our duties with adherence to social work ethics and psychometric standards. In 2000, ASWB had an independent psychometric evaluation of its examinations. The results of that evaluation were that the ASWB examinations are valid, reliable, and defensible.

The ASWB examinations are delivered electronically at 230 ACT test centers nationwide, with nine test centers located within California and ACT plans to expand the number of test centers there.

The examinations contain 150 questions that count toward the score and 20 pretest questions. They are given by computer over a four hour period. Prior to the examination, candidates are given the opportunity to learn how the test functions on the computer and practice making responses. There is also a satisfaction survey given at the end of the examination.

In addition to providing valid and defensible social work licensing examinations, ASWB provides its members with relevant, timely information and publications about professional regulation, as well as services such as continuing education meetings and new board member training. Each year ASWB has two meetings, a spring educational meeting and a fall business meeting of the Delegate Assembly, the governing body of the association. There is no charge to members or invited guests to attend these meetings. ASWB pays travel and lodging expenses for one delegate from each member jurisdiction to attend the fall business meeting. Members and staff of social work regulatory boards that are not ASWB members may attend without charge, but no travel or lodging expenses will be paid. Attendees at the spring educational meeting must pay for their own transportation, lodging, and some meals. The association usually provides a continental breakfast each day, and lunch on the full day of the meeting.

The 2006 Spring Education Meeting will be held in Portland, Oregon, April 27 – 30. The Annual Meeting is scheduled for Baltimore, Maryland, November 10 – 12.

Three new board member training sessions are held each year for members who have been recently appointed to their boards. As a service to our member boards, the association pays for one member from each jurisdiction to attend, on a space-available basis. We usually accommodate 15 to 20 trainees.

Through the ASWB publications, as well as these meetings, members are afforded the opportunity to learn about legal regulation of the profession, and to network with others involved with regulatory boards. Most of our members rate networking as the most important benefit of association membership. There is growing electronic communication among members to keep the networking going. We have a board administrators listserv and a listserv for board members.

Dues paid to the association are based on the number of licensees in the jurisdiction. The maximum amount of annual dues charged is \$2,000.00 for 10,001 or more licensees.

Mr. Paul Riches, Executive Officer
February 17, 2006
Page four

As you can see I feel that we have much to offer any jurisdiction who chooses to be one of our members. I also believe that our association has much to gain from having California once again become one of our members. I hope that you and the board members will favorably consider rejoining ASWB. Please let me know if you have any questions or need more information. More information can also be found on our website, www.aswb.org. I live in Bend, Oregon, which is not that far away. If you so desire, I would be pleased to come to Sacramento to talk with you and the members of the California Board of Behavioral Science Examiners. Thanks for your time and I will look forward to hearing from you.

Sincerely

A handwritten signature in black ink, appearing to read "Roger Kryzanek". The signature is fluid and cursive, with the first name "Roger" being more prominent than the last name "Kryzanek".

Roger Kryzanek, LCSW
President

cc: Ms. Charlene Zettel, Director
California Department of Consumer Affairs

ATTACHMENT

Agenda Item V. A.

Letter from Donna DeAngelis

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May 2, 2006

Mr. Paul Riches
Executive Officer
Board of Behavioral Sciences
1625 North Market Boulevard, Suite S200
Sacramento, California 95834

Dear Mr. Riches:

I was very pleased to hear that the California Board of Behavioral Sciences is considering once again joining with 58 other social work regulatory boards in the United States and Canada in membership in the Association of Social Work Boards (ASWB). The ASWB Communications Director, Mr. Troy Elliott, today sent a membership application and a document describing member benefits to Ms. Christina Kitamura, Administrative Assistant in your office. I am enclosing with this letter a copy of the ASWB Bylaws and other materials about its Approved Continuing Education program, the Social Work Registry, and the report of the most recent practice analysis on which the content of the licensing examinations are determined. Additional publications relevant to examination development and other subjects of interest to social work regulatory boards are also enclosed. Please let me know if you would like to receive additional copies of these material to share with your board members and staff.

According to the ASWB Bylaws, an application for membership reinstatement in the association from a regulatory board that qualifies may be approved by the ASWB Board of Directors, "upon appropriate reapplication and compliance with all conditions set forth by the Board of Directors." Also according to the ASWB Bylaws:

Article III. Definitions, Section 3. Member Board, a "Member Board" shall mean any Board as defined above which is duly accepted into the Association pursuant to these Bylaws, and enters into a contract for the use of the Association's examinations, if applicable.

"If applicable" applies to all social work regulatory boards that use an examination to assess knowledge for minimum competency.

Mr. Paul Riches
May 2, 2006
Page two

Whether or not your board decides to apply for reinstated membership in ASWB, members of the board are welcome to attend the Annual Meeting of the ASWB Delegate Assembly, November 10 – 12, 2006 in Baltimore, Maryland.

If the California Board of Behavioral Sciences makes application for reinstatement, I will keep you informed of the results of each step in the process as it goes along. In the meantime, please let me know if you have any questions or need more information. I hope to meet you in person at the November meeting.

Sincerely,

A handwritten signature in cursive script that reads "Donna DeAngelis". The signature is written in dark ink and is positioned above the typed name and title.

Donna DeAngelis, LICSW, ACSW
Executive Director

Enclosures

ATTACHMENT

Agenda Item V. A.

ASWB Examination Outlines

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BACHELORS EXAMINATION CONTENT OUTLINE

Content Area	Items
I. Human Development and Behavior in the Environment	14%
A. Theoretical approaches to understanding individuals, families, groups, communities, and organizations	
B. Human growth and development	
C. Human behavior in the social environment	
D. Impact of crises and changes	
E. Addictive behaviors	
F. Dynamics of abuse and neglect	
II. Issues of Diversity	7%
III. Assessment in Social Work Practice	20%
A. Social history and collateral data	
B. Use of assessment instruments	
C. Problem identification	
D. Effects of the environment on client system behavior	
E. Assessment of client system's strengths and weaknesses	
F. Assessment of mental and behavioral disorders	
G. Indicators of abuse and neglect	
H. Indicators of danger to self and others	
I. Indicators of crisis	
IV. Direct and Indirect Practice	21%
A. Models of practice	
B. Intervention techniques	
C. Components of the intervention process	
D. Matching intervention with client system needs	
E. Professional use of self	
F. Use of collaborative relationships in social work practice	
V. Communication	10%
A. Communication principles	
B. Communication techniques	
VI. Professional Relationships	5%
A. Relationship concepts	
B. Relationship in practice	
VII. Professional Values and Ethics	13%
A. Responsibility to the client system	
B. Responsibility to the profession	
C. Confidentiality	
D. Self-determination	
VIII. Supervision in Social Work	2%
A. Educational functions of supervision	
B. Administrative functions of supervision	
IX. Practice Evaluation and the Utilization of Research	2%
A. Methods of data collection	
B. Research design and data analysis	
X. Service Delivery	5%
A. Client system rights and entitlements	
B. Implementation of organizational policies and procedures	
XI. Social Work Administration	1%
A. Staffing and human resource management	
B. Social work program management	

MASTERS EXAMINATION CONTENT OUTLINE

Content Area	Items
I. Human Development and Behavior in the Environment	18%
A. Theories and concepts	
B. Application of knowledge	
II. Diversity and Social/Economic Justice	7%
A. Diversity	
B. Social/economic justice and oppression	
III. Assessment, Diagnosis, and Treatment Planning	11%
A. Biopsychosocial history and collateral data	
B. Assessment methods and techniques	
C. Assessment indicators, components, and characteristics	
D. Indicators of abuse and neglect	
E. Intervention planning	
IV. Direct and Indirect Practice	22%
A. Intervention models and methods	
B. The intervention process	
C. Intervention techniques	
D. Intervention with couples and families	
E. Intervention with groups	
F. Intervention with communities and larger systems	
G. Consultation and interdisciplinary collaboration	
V. Communication	7%
A. Communication principles	
B. Communication techniques	
VI. Professional Relationships	5%
A. Relationship concepts	
B. Social worker and client roles	
C. Ethical issues within the relationship	
VII. Professional Values and Ethics	11%
A. Professional values	
B. Legal and ethical issues	
C. Confidentiality	
VIII. Supervision, Administration, and Policy	8%
A. Supervision and staff development	
B. Human resource management	
C. Finance and administration	
IX. Practice Evaluation and the Utilization of Research	2%
A. Data collection	
B. Data analysis	
C. Utilization of research	
X. Service Delivery	9%
A. Service delivery systems	
B. Obtaining services	
C. Effects of policies and procedures on service delivery	

ADVANCED GENERALIST EXAMINATION CONTENT OUTLINE

Content Area	Items
I. Human Development and Behavior in the Environment	10%
A. Theories and models	
B. Human growth and development	
C. Family functioning	
II. Issues of Diversity	5%
III. Assessment, Diagnosis, and Intervention Planning	24%
A. Social history	
B. Use of assessment instruments	
C. Problem identification	
D. Effects of the environment on client behavior	
E. Impact of life stressors on systems	
F. Evaluation of client strengths and weaknesses	
G. Evaluation of mental and behavioral disorders	
H. Abuse and neglect	
I. Indicators of danger to self and others	
J. General assessment issues	
K. Intervention planning	
IV. Direct and Indirect Practice	16%
A. Theories	
B. Methods and processes	
C. Intervention techniques	
D. Intervention with couples and families	
E. Intervention with groups	
F. Intervention with communities	
V. Communication	7%
A. Communication principles	
B. Communication techniques	
VI. Relationship Issues	5%
A. Concepts of social worker - client relationship	
B. Effects of social and psychological factors	
VII. Professional Values and Ethics	12%
A. Values and ethics	
B. Confidentiality	
C. Self-determination	
VIII. Supervision and Professional Development	3%
IX. Practice Evaluation and the Utilization of Research	4%
A. Data collection	
B. Data analysis and utilization	
X. Service Delivery	11%
A. Service delivery systems and processes	
B. Effects of policies, procedures, and legislation	
C. Methods of social work advocacy	
D. Interdisciplinary collaboration	
XI. Administration	3%
A. Management	
B. Human resource management	
C. Financial management	

CLINICAL EXAMINATION CONTENT OUTLINE

Content Area	Items
I. Human Development and Behavior in the Environment	22%
A. Theories of human development and behavior	
B. Human development in the life cycle	
C. Human behavior	
D. Impact of crises and changes	
E. Family functioning	
F. Addictions	
G. Abuse and neglect	
II. Issues of Diversity	6%
A. Effects of culture, race, and/or ethnicity	
B. Effects of sexual orientation and/or gender	
C. Effects of age and/or disability	
III. Diagnosis and Assessment	16%
A. Assessment	
B. Information gathering	
C. Diagnostic classifications	
D. Indicators of abuse and neglect	
E. Indicators of danger to self and others	
IV. Psychotherapy and Clinical Practice	16%
A. Intervention theories and models	
B. The intervention process	
C. Treatment planning	
D. Intervention techniques	
E. Intervention with couples and families	
F. Intervention with groups	
V. Communication	8%
A. Communication principles	
B. Communication techniques	
VI. The Therapeutic Relationship	7%
A. Relationship theories	
B. Relationship practice	
VII. Professional Values and Ethics	10%
A. Value issues	
B. Legal and ethical issues	
C. Confidentiality	
VIII. Clinical Supervision, Consultation, and Staff Development	4%
A. Social work supervision	
B. Consultation and interdisciplinary collaboration	
C. Staff development	
IX. Practice Evaluation and the Utilization of Research	1%
A. Evaluation techniques	
B. Utilization of research	
X. Service Delivery	5%
A. Policies and procedures of service delivery	
B. Processes of service delivery	
XI. Clinical Practice and Management	5%
A. Advocacy	
B. Finance	
C. Management and human resource issues	

ATTACHMENT

Agenda Item V. A.

February 4, 1999
Examination Committee Meeting Minutes

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(approved June 4, 1999)

**BOARD OF BEHAVIORAL SCIENCES
 EXAMINATION COMMITTEE
 MEETING MINUTES**

FEBRUARY 4, 1999

**UNIVERSITY OF CALIFORNIA LOS ANGELES
 BRADLEY HALL
 LOS ANGELES, CA**

MEMBERS PRESENT

Marsena Buck, LCSW Member, Committee Chair
 Selma Fields, MFCC Member
 Lorie Rice, Public Member
 Christina Chen, Public Member

MEMBERS ABSENT

STAFF PRESENT

Sherry Mehl, Executive Officer
 Denise Pellerin, Assistant Executive Officer
 Dan Buntjer, Legal Counsel
 Julie McAuliffe, Administrative Analyst

GUEST LIST ON FILE

The meeting was called to order at 10:45 a.m.

1. APPROVAL OF MINUTES

LORIE RICE MOVED, SELMA FIELDS SECONDED, AND THE COMMITTEE CONCURRED TO APPROVE THE MINUTES OF AUGUST 6, 1998.

LORIE RICE MOVED, SELMA FIELDS SECONDED, AND THE COMMITTEE CONCURRED TO APPROVE THE MINUTES OF OCTOBER 29, 1998.

2. PRESENTATION REGARDING THE EXAMINATION PROCESS

Ms. Mehl introduced Dr. Norman Hertz from the Office of Examination Resources (OER) and stated that OER is under the Department of Consumer Affairs and provides oversight for all the examinations administered by the Board. In addition, the Board contracts with OER to assist in all of the development of our examinations. They are also responsible for analyzing all of the Board's statistical information. Dr. Hertz explained that OER is considered an independent agency. Their mission is to advocate for the candidates and for the consumers by building

examinations that test candidates ability to practice safely, which provides protection to the consumer.

Examination development and preparation for the Board are continual. OER and the Board have made great strides in examination redevelopment in the last two years. Occupational analysis for the MFCC and the LCSW professions were recently conducted. The results of the analysis define current practice in California, and are used as a basis for the development of the current written and oral examinations. The data showed that ethical and legal issues should be tested as separate areas. The data also indicated that the area of human diversity should be tested as a separate area also. Subject matter experts were able to design the examinations to test this issue sensitively.

The Board and OER has had concerns with the American Association of State Social Work Boards (AASSWB) national clinical written examination. Concerns included the job analysis survey conducted by the AASSWB which did not include a representative number of licensees in California and the fact that the first time pass rate is 89% for California candidates. Based on these concerns as well as the completion of the current occupational analysis, there was a determination made that there was a need for a new state constructed written examination. The examination has been developed and constructed and will begin to be administered in late April 1999. The work involved in developing an examination includes subject matter experts and numerous workshops.

The Master Service Agreement is in place and the vendor offers the written examinations electronically on a continuous basis. The MFT examination went on line on February 1, 1999, and ran very smoothly. The vendor has also been able to accommodate candidates who wish to take the written examination before the final filing date for the next oral examination. The Board was the first board within the Department to begin contracting with this vendor. All boards may eventually administer their examinations through this vendor. Ms. Mehl stated that this vendor has been very responsive to all of our needs. A modem is set up in the office and we are now able to know the results of candidates daily. Also, we will eventually be paperless in the written examination process.

Dr. Hertz added that examination security includes photographs of all candidates to ensure to actual person is participating in the examination. He then thanked Ms. Mehl for all of her interest and positive efforts in the implementation of this process.

Dr. Hertz stated that he feels very positive about the vignette development process. Also, the oral examination rating scale has been expanded and has been working very well. Another rating level has been added which allows examiners to make some distinctions in relation to minimum competency. The process of determining minimum competency includes a critical incident methodology workshop. Behaviors that represent performance are identified and how this behavior relates to subject matter areas in the examinations are determined. A questionnaire is created and mailed to licensees asking them to identify the content area where the identified behavior belongs and the level of effectiveness on a scale of one to nine. If there was a deviation of the survey determination the behavior was not used in the examination process. The data is also used to set the passing scores. Subject matter experts assist in this process.

Dr. Hertz feels that more work is needed in the written examination process. A larger item pool needs to be created. He explained every item written goes back to a reference book and has asked schools to assist in identifying which text books are currently being used in their programs.

Ms. Mehl stated that we have received quite a lot of information and OER and the Board are in the process of compiling this information. The Board now has its own library and hopes that we will eventually be able to provide a current reference list.

Dr. Hertz suggested creating more versions of the written examination. A Budget Change Proposal will be submitted for further written examination development. There is a need to create another complete examination in case there is ever a breach of examination security.

Dr. Hertz stated that he and Ms. Mehl work collaboratively together and it is a pleasure to work with her.

Ms. Mehl stated that the examination statistics continue to be strong and the inter rater reliability continues to be consistent.

Abby Franklin, LCSW and representing the California Society of Clinical Social Work, stated that as a person involved in the examination construction process, it has been very exciting and has been a privilege to be a part of this process. She then questioned about the provisions for security for the written examination. Ms. Mehl explained that photographs are taken of the candidate and are compared with the photograph included in the candidate's file and candidates are required to sign a security agreement. The Examination Unit and Board staff are located in a secure office and the examination materials are kept in a locked room.

The new contractor has assured Ms. Mehl that they have been offering examinations for quite a long time and are familiar with current possible examination confidentiality breaches. There is also specific examiner training that relates to security and examiners are trained on what to look for.

Ms. Mehl cautioned future candidates that the preparation materials currently offered by independent companies may contain inaccurate information.

Dr. Hertz indicated that OER provides a more secure item writing environment. One staffperson and one back up staffperson are the only two staff members in OER that have accessibility to the materials and all materials are kept in a locked room. Also, examination questions are scrambled for each examination so there is no possibility that two candidates can take the same examination.

Jan Lee Wong, Executive Director of the National Association of Social Workers, questioned the surveys that were sent by the AASSWB to California LCSW's. Ms. Mehl indicated that only twelve California LCSW's were surveyed by AASSWB and this is not a representative number of the current practice. Over 2,000 LCSW's were surveyed during the Board's 1998 occupational analysis. There were also questions on the AASSWB survey in relation to independent and private practice and their understandings of these practices are different than independent California practice. She then indicated that we did survey licensees in various types of settings to grasp a better understanding of the current practice. We also have compared the AASSWB examination outline and our outline and it is very easy to recognize the differences. Mr. Wong

questioned what will happen to licensees from out of state who apply for licensure in California and have taken the AASSWB clinical level examination. Ms. Mehl stated that we would accept passing AASSWB examination scores from an applicant so long as the examination was taken during the period of time the Board participated in the examination. After we begin administering the state constructed written examination, we will require an out of state application to take this examination. Mr. Wong then commented on the possibility of offering the examination in other languages in the future.

David Fox, MFCC, complimented the Board and Dr. Hertz on the current examination process. He then asked that the Board review the last MFT oral examination vignettes to determine if the issue of diversity is addressed throughout the vignettes.

Francine Neely from Pepperdine University complemented the Board and the Office of Examination Resources on the examination process. She offered to meet with Ms. Mehl and OER to assist in the book reference collaboration.

Mary Riemersma, Executive Director of the California Association of Marriage and Family Therapists, stated that the association was very excited and appreciative of the current MFT examination process and the statistical results.

Ms. Buck thanked Dr. Hertz for providing all of the information to the Committee.

3. EXAMINATION STATISTICS

The statistics were provided in the meeting binder. Ms. Mehl stated that the oral statistics were printed prior to the appeal results and pointed out that the pass rate for the first time takers has increased.

4. ORAL EXAMINATION APPEAL INFORMATION

Ms. Mehl stated that the Committee had requested to review this information. The appeal process has been streamlined within the office and has been working very smoothly.

The meeting adjourned at 11:50 a.m.

**State of California
Board of Behavioral Sciences**

M e m o r a n d u m

To: Board Members

Date: October 31, 2006

From: Justin Sotelo
Regulations Analyst

Telephone: (916) 574-7836

Subject: Agenda Item V.B. - Propose to Amend Title 16, California Code of Regulations Sections 1887(a), 1887(b), 1887.2(a), and 1887.3(a) Regarding Continuing Education Course Requirements

Background

At its April 21, 2006 meeting, the Consumer Protection Committee discussed the distinctions between conventional, self-study, and online continuing education (CE) courses. Licensees are currently permitted to take an unlimited amount of CE by conventional or online means; however, hours earned through self-study courses are limited to one-third of the total required CE hours. The Committee decided that there was no reason to limit the amount of CE obtained by any one method and directed staff to bring such a proposal back to the Committee.

On September 20, 2006, proposed language was brought back to the Committee for review. The Committee recommended that some additional minor modifications be incorporated [moving some language from Section 1887(b) to 1887(a) to incorporate the definition of self-study into the definition of a CE course] and recommended that the proposed language go forward to the Board for review and approval.

Recommendation

Amend Title 16, California Code of Regulations, Sections 1887(a), 1887(b), 1887.2(a), and 1887.3(a) to delete limitations regarding hours of self-study.

Attachments

Proposed Language

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ATTACHMENT

Agenda Item V B

Proposed Language - Attachment 1

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BOARD OF BEHAVIORAL SCIENCES
PROPOSED LANGUAGE
Title 16, California Code of Regulations (CCR)
Sections 1887(a), 1887(b), 1887.2(a), 1887.3(a)

Amend CCR Sections 1887(a), 1887(b), 1887.2(a), and 1887.3(a) as follows:

§1887

As used in this article:

(a) A continuing education "course" means a form of systematic learning at least one hour in length including, but not limited to, academic studies, extension studies, lectures, conferences, seminars, workshops, viewing of videotapes or film instruction, viewing or participating in other audiovisual activities including interactive video instruction and activities electronically transmitted from another location, studies performed at a licensee's residence, office, or other private location, listening to audiotapes or participating in self-assessment testing (open book tests that are completed by the member, submitted to the provider, graded, and returned to the member with correct answers and an explanation of why the answer chosen by the provider was the correct answer) which has been verified and approved by the continuing education provider, ~~and self-study courses.~~

~~(b) A "self-study course" means a form of systematic learning performed at a licensee's residence, office, or other private location including, but not limited to, listening to audiotapes or participating in self-assessment testing (open-book tests that are completed by the member, submitted to the provider, graded, and returned to the member with correct answers and an explanation of why the answer chosen by the provider was the correct answer).~~

§1887.2

(a) An initial licensee shall complete at least eighteen (18) hours of continuing education, ~~of which no more than six (6) hours may be earned through self-study courses,~~ education prior to his or her first license renewal.

§1887.3

(a) A licensee shall accrue at least thirty-six (36) hours of continuing education courses as defined in Section 1887.4. ~~A licensee may accrue no more than twelve (12) hours of continuing education earned through self-study courses during a single renewal period.~~

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**State of California
Board of Behavioral Sciences**

Memorandum

To: Board Members
From: Christy Berger
Legislation Analyst
Date: October 30, 2006
Telephone: (916) 574-7847
Subject: **Agenda Item V. C. – Recommendation # 3 - Sponsor Legislation to Add Violations of the Health and Safety Code Regarding Patient Records and Violations of the Telemedicine Statute to the Definition of Unprofessional Conduct**

Background

Patient Records/Health and Safety Code

At the April 17, 2006 Consumer Protection Committee Meeting, the Committee reviewed the Board's unprofessional conduct statutes. The Committee was informed that the Board receives numerous complaints regarding licensees who decline to provide client records pursuant to Health and Safety Code (HSC) Section 123110. Although the Enforcement Analysts attempt to assist clients, there is no recourse for noncompliance because the Board does not have a provision in law that requires licensees to provide the records.

A proposal was brought before the Board at its May 18, 2006 meeting that would have added a violation of HSC Section 123110 to the definition of unprofessional conduct. At this meeting, the suggestion was made to instead reference the full chapter of the HSC that pertains to the release of patient records, as there are other applicable sections. The revised proposal was brought back to the Consumer Protection Committee at its September 20, 2006 meeting. A suggestion was made by Mary Riemersma of the California Association of Marriage and Family Therapists (CAMFT) to modify the language to indicate a "willful violation" as opposed to simply a "failure to comply."

Telemedicine

In 1996, California passed legislation pertaining to the practice of "telemedicine" (Business and Professions Code [BPC] Section 2290.5). In 1999, the statute was amended to require marriage and family therapists (MFT) and clinical social workers (LCSW) to comply with this statute. The Board has been treating BPC Section 2290.5 as part of its law even though it is part of the Medical Practice Act. However, it would be difficult for the Board to take enforcement action under a provision that is not directly a part of the Board's law.

Regulations vs. Statute

Staff reviewed the regulations pertaining to unprofessional conduct and noted that the regulations duplicate the statute, with a couple of exceptions. The failure to report abuse of a child, elder, or dependent adult are in MFT and LCSW regulations, but are not in statute. To have a consistent, cohesive unprofessional conduct law, it is preferable to list all instances of potential unprofessional conduct in one place.

Recommendation

The Consumer Protection Committee, at its September 20, 2006 meeting, voted to recommend to the Board that the proposal be approved, as follows:

1. Amend unprofessional conduct statutes for MFTs and LCSWs (BPC Sections 4982 and 4992.3, respectively) as follows:
 - Delete the regulation regarding failure to comply with child, elder, or dependent adult abuse reporting requirements and add it to the statute.
 - Add a willful violation of Division 106, Part 1, Chapter 1 of the HSC pertaining to release of records to the statute.
 - Add the failure to comply with telemedicine requirements of BPC Section 2290.5 to the statute.
 - Make minor editorial changes.
2. Amend unprofessional conduct statutes for LEPs (BPC Section 4986.70) as follows:
 - Add the failure to comply with Division 106, Part 1, Chapter 1 of the HSC pertaining to release of records to the statute.

Attachments

- A. Proposed Language
- B. Division 106, Part 1, Chapter 1 of the HSC
- C. BPC Section 2290.5, Telemedicine

ATTACHMENT

Agenda Item V. C.

Proposed Language

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BOARD OF BEHAVIORAL SCIENCES
PROPOSED LANGUAGE
Business and Professions Code (BPC) Sections 4982, 4986.70, and 4992.3
Title 16, California Code of Regulations (CCR) Sections 1845 and 1881

Amend BPC Sections 4982, 4986.70, and 4992.3 as follows:

MFT - §4982

The board may ~~refuse to issue any~~ deny a registration or license, or may suspend or revoke the license or registration of any registrant or licensee if ~~the applicant, licensee, or registrant~~ he or she has been guilty of unprofessional conduct. Unprofessional conduct ~~shall include, but not be limited to~~ includes, but is not limited to, the following:

(w) Failure to comply with the child abuse reporting requirements of Penal Code Section 11166.

(x) Failure to comply with the elder and dependent adult abuse reporting requirements of Welfare and Institutions Code Section 15630.

(y) ~~Failure to comply with~~ Willful violation of Division 106, Part 1, Chapter 1 of the Health and Safety Code.

(z) Failure to comply with Business and Professions Code Section 2290.5.

LEP §4986.70

The board may deny a license or may suspend or revoke the license of a licensee if he or she has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

(x) ~~Failure to comply with~~ Willful violation of Division 106, Part 1, Chapter 1 of the Health and Safety Code.

LCSW §4992.3

The board may ~~refuse to issue~~ deny a registration or a license, or may suspend or revoke the license or registration of any registrant or licensee if ~~the applicant, licensee, or registrant~~ he or she has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to the following:

(t) Failure to comply with the child abuse reporting requirements of Penal Code Section 11166.

(u) Failure to comply with the elder and dependent adult abuse reporting requirements of Welfare and Institutions Code Section 15630.

(v) ~~Failure to comply with~~ Willful violation of Division 106, Part 1, Chapter 1 of the Health and Safety Code.

(w) Failure to comply with Business and Professions Code Section 2290.5.

Amend Title 16, CCR Sections 1845 and 1881 as follows:

MFT – § 1845

As used in Section 4982 of the code, unprofessional conduct includes, but is not limited to:

- ~~(a) Performing or holding himself or herself out as able to perform professional services beyond his or her field or fields of competence as established by his or her education, training and/or experience.~~
- ~~(b) Permitting a trainee or intern under his or her supervision or control to perform or permitting the trainee or intern to hold himself or herself out as competent to perform professional services beyond the trainee's or intern's level of education, training and/or experience.~~
- ~~(c) Failing to comply with the child abuse reporting requirements of Penal Code Section 11166.~~
- ~~(d) Failing to comply with the elder and dependent adult abuse reporting requirements of Welfare and Institutions Code Section 15630.~~

LCSW – § 1881

~~The board may suspend or revoke the license of a licensee or may refuse to issue a license to a person who:~~

- ~~(a) Misrepresents the type or status of license held by such person or otherwise misrepresents or permits the misrepresentation of his or her professional qualifications or affiliations.~~
- ~~(b) Impersonates a licensee or who allows another person to use his or her license.~~
- ~~(c) Aids or abets an unlicensed person to engage in conduct requiring a license.~~
- ~~(d) Intentionally or recklessly causes physical or emotional harm to a client.~~
- ~~(e) Commits any dishonest, corrupt, or fraudulent act which is substantially related to the qualifications, functions or duties of a licensee.~~
- ~~(f) Has sexual relations with a client, or who solicits sexual relations with a client, or who commits an act of sexual abuse, or who commits an act of sexual misconduct, or who commits an act punishable as a sexual related crime if such act or solicitation is substantially related to the qualifications, functions or duties of a Licensed Clinical Social Worker.~~
- ~~(g) Performs or holds himself or herself out as able to perform professional services beyond his or her field or fields of competence as established by his or her education, training and/or experience.~~

~~(h) Permits a person under his or her supervision or control to perform or permits such person to hold himself or herself out as competent to perform professional services beyond the level of education, training and/or experience of that person.~~

~~(i) Fails to maintain the confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client during the course of treatment and all information about the client which is obtained from tests or other such means.~~

~~(j) Prior to the commencement of treatment, fails to disclose to the client, or prospective client, the fee to be charged for the professional services, or the basis upon which such fee will be computed.~~

~~(k) Advertises in a manner which is false or misleading.~~

~~(l) Reproduces or describes in public or in publications subject to general public distribution, any psychological test or other assessment device, the value of which depends in whole or in part on the naivete of the subject, in ways that might invalidate such test or device. The licensee shall limit access to such test or device to persons with professional interest who are expected to safeguard their use.~~

~~(m) Commits an act or omission which falls sufficiently below that standard of conduct of the profession as to constitute an act of gross negligence.~~

~~(n) Pays, accepts or solicits any consideration, compensation or remuneration for the referral of professional clients. All consideration, compensation or remuneration must be in relation to professional counseling services actually provided by the licensee. Nothing in this section shall prevent collaboration among two or more licensees in a case or cases. However, no fee shall be charged for such collaboration except when disclosure of such fee is made in compliance with subparagraph (j) above.~~

~~(o) Fails to comply with the child abuse reporting requirements of Penal Code Section 11166.~~

~~(p) Fails to comply with the elder and dependent adult abuse reporting requirements of Welfare and Institution Code Section 15630.~~

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ATTACHMENT

Agenda Item V. C.

Division 106, Part 1, Chapter 1 of the HSC

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**DIVISION 106, PART 1, CHAPTER 1 OF THE HEALTH AND SAFETY CODE
SECTION 123100-123149.5**

123100. The Legislature finds and declares that every person having ultimate responsibility for decisions respecting his or her own health care also possesses a concomitant right of access to complete information respecting his or her condition and care provided. Similarly, persons having responsibility for decisions respecting the health care of others should, in general, have access to information on the patient's condition and care. It is, therefore, the intent of the Legislature in enacting this chapter to establish procedures for providing access to health care records or summaries of those records by patients and by those persons having responsibility for decisions respecting the health care of others.

123105. As used in this chapter:

- (a) "Health care provider" means any of the following:
- (1) A health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2.
 - (2) A clinic licensed pursuant to Chapter 1 (commencing with Section 1200) of Division 2.
 - (3) A home health agency licensed pursuant to Chapter 8 (commencing with Section 1725) of Division 2.
 - (4) A physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or pursuant to the Osteopathic Act.
 - (5) A podiatrist licensed pursuant to Article 22 (commencing with Section 2460) of Chapter 5 of Division 2 of the Business and Professions Code.
 - (6) A dentist licensed pursuant to Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code.
 - (7) A psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code.
 - (8) An optometrist licensed pursuant to Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code.
 - (9) A chiropractor licensed pursuant to the Chiropractic Initiative Act.
 - (10) A marriage and family therapist licensed pursuant to Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code.
 - (11) A clinical social worker licensed pursuant to Chapter 14 (commencing with Section 4990) of Division 2 of the Business and Professions Code.
 - (12) A physical therapist licensed pursuant to Chapter 5.7 (commencing with Section 2600) of Division 2 of the Business and Professions Code.
- (b) "Mental health records" means patient records, or discrete portions thereof, specifically relating to evaluation or treatment of a mental disorder. "Mental health records" includes, but is not limited to, all alcohol and drug abuse records.
- (c) "Patient" means a patient or former patient of a health care provider.
- (d) "Patient records" means records in any form or medium maintained by, or in the custody or control of, a health care provider relating to the health history, diagnosis, or condition of a patient, or relating to treatment provided or proposed to be provided to the patient. "Patient records" includes only records pertaining to the patient requesting the records or whose representative requests the records. "Patient records" does not include information given in confidence to a health care provider by a person other than another health care provider or the patient, and that material may be removed from any records prior to inspection or copying under Section 123110 or 123115. "Patient records" does not include information contained in aggregate form, such as indices, registers, or logs.

(e) "Patient's representative" or "representative" means a parent or the guardian of a minor who is a patient, or the guardian or conservator of the person of an adult patient, or the beneficiary or personal representative of a deceased patient.

(f) "Alcohol and drug abuse records" means patient records, or discrete portions thereof, specifically relating to evaluation and treatment of alcoholism or drug abuse.

123110. (a) Notwithstanding Section 5328 of the Welfare and Institutions Code, and except as provided in Sections 123115 and 123120, any adult patient of a health care provider, any minor patient authorized by law to consent to medical treatment, and any patient representative shall be entitled to inspect patient records upon presenting to the health care provider a written request for those records and upon payment of reasonable clerical costs incurred in locating and making the records available. However, a patient who is a minor shall be entitled to inspect patient records pertaining only to health care of a type for which the minor is lawfully authorized to consent. A health care provider shall permit this inspection during business hours within five working days after receipt of the written request. The inspection shall be conducted by the patient or patient's representative requesting the inspection, who may be accompanied by one other person of his or her choosing.

(b) Additionally, any patient or patient's representative shall be entitled to copies of all or any portion of the patient records that he or she has a right to inspect, upon presenting a written request to the health care provider specifying the records to be copied, together with a fee to defray the cost of copying, that shall not exceed twenty-five cents (\$0.25) per page or fifty cents (\$0.50) per page for records that are copied from microfilm and any additional reasonable clerical costs incurred in making the records available.

The health care provider shall ensure that the copies are transmitted within 15 days after receiving the written request.

(c) Copies of X-rays or tracings derived from electrocardiography, electroencephalography, or electromyography need not be provided to the patient or patient's representative under this section, if the original X-rays or tracings are transmitted to another health care provider upon written request of the patient or patient's representative and within 15 days after receipt of the request. The request shall specify the name and address of the health care provider to whom the records are to be delivered. All reasonable costs, not exceeding actual costs, incurred by a health care provider in providing copies pursuant to this subdivision may be charged to the patient or representative requesting the copies.

(d) (1) Notwithstanding any provision of this section, and except as provided in Sections 123115 and 123120, any patient or former patient or the patient's representative shall be entitled to a copy, at no charge, of the relevant portion of the patient's records, upon presenting to the provider a written request, and proof that the records are needed to support an appeal regarding eligibility for a public benefit program. These programs shall be the Medi-Cal program, social security disability insurance benefits, and Supplemental Security Income/State Supplementary Program for the Aged, Blind and Disabled (SSI/SSP) benefits. For purposes of this subdivision, "relevant portion of the patient's records" means those records regarding services rendered to the patient during the time period beginning with the date of the patient's initial application for public benefits up to and including the date that a final determination is made by the public benefits program with which the patient's application is pending.

(2) Although a patient shall not be limited to a single request, the patient or patient's representative shall be entitled to no more than one copy of any relevant portion of his or her record free of charge.

(3) This subdivision shall not apply to any patient who is represented by a private attorney who is paying for the costs related to the patient's appeal, pending the outcome of that appeal.

For purposes of this subdivision, "private attorney" means any attorney not employed by a nonprofit legal services entity.

(e) If the patient's appeal regarding eligibility for a public benefit program specified in subdivision (d) is successful, the hospital or other health care provider may bill the patient, at the rates specified in subdivisions (b) and (c), for the copies of the medical records previously provided free of charge.

(f) If a patient or his or her representative requests a record pursuant to subdivision (d), the health care provider shall ensure that the copies are transmitted within 30 days after receiving the written request.

(g) This section shall not be construed to preclude a health care provider from requiring reasonable verification of identity prior to permitting inspection or copying of patient records, provided this requirement is not used oppressively or discriminatorily to frustrate or delay compliance with this section. Nothing in this chapter shall be deemed to supersede any rights that a patient or representative might otherwise have or exercise under Section 1158 of the Evidence Code or any other provision of law. Nothing in this chapter shall require a health care provider to retain records longer than required by applicable statutes or administrative regulations.

(h) This chapter shall not be construed to render a health care provider liable for the quality of his or her records or the copies provided in excess of existing law and regulations with respect to the quality of medical records. A health care provider shall not be liable to the patient or any other person for any consequences that result from disclosure of patient records as required by this chapter. A health care provider shall not discriminate against classes or categories of providers in the transmittal of X-rays or other patient records, or copies of these X-rays or records, to other providers as authorized by this section.

Every health care provider shall adopt policies and establish procedures for the uniform transmittal of X-rays and other patient records that effectively prevent the discrimination described in this subdivision. A health care provider may establish reasonable conditions, including a reasonable deposit fee, to ensure the return of original X-rays transmitted to another health care provider, provided the conditions do not discriminate on the basis of, or in a manner related to, the license of the provider to which the X-rays are transmitted.

(i) Any health care provider described in paragraphs (4) to (10), inclusive, of subdivision (a) of Section 123105 who willfully violates this chapter is guilty of unprofessional conduct. Any health care provider described in paragraphs (1) to (3), inclusive, of subdivision (a) of Section 123105 that willfully violates this chapter is guilty of an infraction punishable by a fine of not more than one hundred dollars (\$100). The state agency, board, or commission that issued the health care provider's professional or institutional license shall consider a violation as grounds for disciplinary action with respect to the licensure, including suspension or revocation of the license or certificate.

(j) This section shall be construed as prohibiting a health care provider from withholding patient records or summaries of patient records because of an unpaid bill for health care services. Any health care provider who willfully withholds patient records or summaries of patient records because of an unpaid bill for health care services shall be subject to the sanctions specified in subdivision (i).

123111. (a) Any adult patient who inspects his or her patient records pursuant to Section 123110 shall have the right to provide to the health care provider a written addendum with respect to any item or statement in his or her records that the patient believes to be incomplete or incorrect. The addendum shall be limited to 250 words per alleged incomplete or incorrect item in the patient's record and shall clearly indicate in writing that the patient wishes the addendum to be made a part of his or her record.

(b) The health care provider shall attach the addendum to the patient's records and shall include that addendum whenever the health care provider makes a disclosure of the allegedly incomplete or incorrect portion of the patient's records to any third party.

(c) The receipt of information in a patient's addendum which contains defamatory or otherwise unlawful language, and the inclusion of this information in the patient's records, in accordance with subdivision (b), shall not, in and of itself, subject the health care provider to liability in any civil, criminal, administrative, or other proceeding.

(d) Subdivision (f) of Section 123110 and Section 123120 shall be applicable with respect to any violation of this section by a health care provider.

123115. (a) The representative of a minor shall not be entitled to inspect or obtain copies of the minor's patient records in either of the following circumstances:

(1) With respect to which the minor has a right of inspection under Section 123110.

(2) Where the health care provider determines that access to the patient records requested by the representative would have a detrimental effect on the provider's professional relationship with the minor patient or the minor's physical safety or psychological well-being. The decision of the health care provider as to whether or not a minor's records are available for inspection under this section shall not attach any liability to the provider, unless the decision is found to be in bad faith.

(b) When a health care provider determines there is a substantial risk of significant adverse or detrimental consequences to a patient in seeing or receiving a copy of mental health records requested by the patient, the provider may decline to permit inspection or provide copies of the records to the patient, subject to the following conditions:

(1) The health care provider shall make a written record, to be included with the mental health records requested, noting the date of the request and explaining the health care provider's reason for refusing to permit inspection or provide copies of the records, including a description of the specific adverse or detrimental consequences to the patient that the provider anticipates would occur if inspection or copying were permitted.

(2) The health care provider shall permit inspection by, or provide copies of the mental health records to, a licensed physician and surgeon, licensed psychologist, licensed marriage and family therapist, or licensed clinical social worker, designated by request of the patient. Any marriage and family therapist registered intern, as defined in Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code, may not inspect the patient's mental health records or obtain copies thereof, except pursuant to the direction or supervision of a licensed professional specified in subdivision (f) of Section 4980.40 of the Business and Professions Code. Prior to providing copies of mental health records to a marriage and family therapist registered intern, a receipt for those records shall be signed by the supervising licensed professional. The licensed physician and surgeon, licensed psychologist, licensed marriage and family therapist, licensed clinical social worker, or marriage and family therapist registered intern to whom the records are provided for inspection or copying shall not permit inspection or copying by the patient.

(3) The health care provider shall inform the patient of the provider's refusal to permit him or her to inspect or obtain copies of the requested records, and inform the patient of the right to require the provider to permit inspection by, or provide copies to, a licensed physician and surgeon, licensed psychologist, licensed marriage and family therapist, or licensed clinical social worker, designated by written authorization of the patient.

(4) The health care provider shall indicate in the mental health records of the patient whether the request was made under paragraph (2).

123120. Any patient or representative aggrieved by a violation of Section 123110 may, in addition to any other remedy provided by law, bring an action against the health care provider to enforce the obligations prescribed by Section 123110. Any judgment rendered in the action may, in the discretion of the court, include an award of costs and reasonable attorney fees to the prevailing party.

123125. (a) This chapter shall not require a health care provider to permit inspection or provide copies of alcohol and drug abuse records where, or in a manner, prohibited by Section 408 of the federal Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255) or Section 333 of the federal Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (Public Law 91-616), or by regulations adopted pursuant to these federal laws. Alcohol and drug abuse records subject to these federal laws shall also be subject to this chapter, to the extent that these federal laws do not prohibit disclosure of the records. All other alcohol and drug abuse records shall be fully subject to this chapter.

(b) This chapter shall not require a health care provider to permit inspection or provide copies of records or portions of records where or in a manner prohibited by existing law respecting the confidentiality of information regarding communicable disease carriers.

123130. (a) A health care provider may prepare a summary of the record, according to the requirements of this section, for inspection and copying by a patient. If the health care provider chooses to prepare a summary of the record rather than allowing access to the entire record, he or she shall make the summary of the record available to the patient within 10 working days from the date of the patient's request. However, if more time is needed because the record is of extraordinary length or because the patient was discharged from a licensed health facility within the last 10 days, the health care provider shall notify the patient of this fact and the date that the summary will be completed, but in no case shall more than 30 days elapse between the request by the patient and the delivery of the summary. In preparing the summary of the record the health care provider shall not be obligated to include information that is not contained in the original record.

(b) A health care provider may confer with the patient in an attempt to clarify the patient's purpose and goal in obtaining his or her record. If as a consequence the patient requests information about only certain injuries, illnesses, or episodes, this subdivision shall not require the provider to prepare the summary required by this subdivision for other than the injuries, illnesses, or episodes so requested by the patient. The summary shall contain for each injury, illness, or episode any information included in the record relative to the following:

- (1) Chief complaint or complaints including pertinent history.
- (2) Findings from consultations and referrals to other health care providers.
- (3) Diagnosis, where determined.
- (4) Treatment plan and regimen including medications prescribed.
- (5) Progress of the treatment.
- (6) Prognosis including significant continuing problems or conditions.
- (7) Pertinent reports of diagnostic procedures and tests and all discharge summaries.
- (8) Objective findings from the most recent physical examination, such as blood pressure, weight, and actual values from routine laboratory tests.

(c) This section shall not be construed to require any medical records to be written or maintained in any manner not otherwise required by law.

(d) The summary shall contain a list of all current medications prescribed, including dosage, and any sensitivities or allergies to medications recorded by the provider.

(e) Subdivision (c) of Section 123110 shall be applicable whether or not the health care provider elects to prepare a summary of the record.

(f) The health care provider may charge no more than a reasonable fee based on actual time and cost for the preparation of the summary. The cost shall be based on a computation of the actual time spent preparing the summary for availability to the patient or the patient's representative. It is the intent of the Legislature that summaries of the records be made available at the lowest possible cost to the patient.

123135. Except as otherwise provided by law, nothing in this chapter shall be construed to grant greater access to individual patient records by any person, firm, association, organization, partnership, business trust, company, corporation, or municipal or other public corporation, or government officer or agency. Therefore, this chapter does not do any of the following:

(a) Relieve employers of the requirements of the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code).

(b) Relieve any person subject to the Insurance Information and Privacy Protection Act (Article 6.6 (commencing with Section 791) of Chapter 1 of Part 2 of Division 1 of the Insurance Code) from the requirements of that act.

(c) Relieve government agencies of the requirements of the Information Practices Act of 1977 (Title 1.8 (commencing with Section 1798) of Part 4 of Division 3 of the Civil Code).

123140. The Information Practices Act of 1977 (Title 1.8 (commencing with Section 1798) of Part 4 of Division 3 of the Civil Code) shall prevail over this chapter with respect to records maintained by a state agency.

123145. (a) Providers of health services that are licensed pursuant to Sections 1205, 1253, 1575 and 1726 have an obligation, if the licensee ceases operation, to preserve records for a minimum of seven years following discharge of the patient, except that the records of unemancipated minors shall be kept at least one year after the minor has reached the age of 18 years, and in any case, not less than seven years.

(b) The department or any person injured as a result of the licensee's abandonment of health records may bring an action in a proper court for the amount of damage suffered as a result thereof.

In the event that the licensee is a corporation or partnership that is dissolved, the person injured may take action against that corporation's or partnership's principle officers of record at the time of dissolution.

(c) Abandoned means violating subdivision (a) and leaving patients treated by the licensee without access to medical information to which they are entitled pursuant to Section 123110.

123147. (a) Except as provided in subdivision (b), all health facilities, as defined in Section 1250, and all primary care clinics that are either licensed under Section 1204 or exempt from licensure under Section 1206, shall include a patient's principal spoken language on the patient's health records.

(b) Any long-term health care facility, as defined in Section 1418, that already completes the minimum data set form as specified in Section 14110.15 of the Welfare and Institutions Code, including documentation of a patient's principal spoken language, shall be deemed to be in compliance with subdivision (a).

123148. (a) Notwithstanding any other provision of law, a health care professional at whose request a test is performed shall provide or arrange for the provision of the results of a clinical laboratory test to the patient who is the subject of the test if so requested by the patient, in oral or written form. The results shall be conveyed in plain language and in oral or written form, except the results may be conveyed in electronic form if requested by the patient and if deemed most appropriate by the health care professional who requested the test.

(b) (1) Consent of the patient to receive his or her laboratory results by Internet posting or other electronic means shall be obtained in a manner consistent with the requirements of Section 56.10 or 56.11 of the Civil Code. In the event that a health care professional arranges for the provision of test results by Internet posting or other electronic manner, the results shall be delivered to a patient in a reasonable time period, but only after the results have been reviewed by the health care professional. Access to clinical laboratory test results shall be restricted by the use of a secure personal identification number when the results are delivered to a patient by Internet posting or other electronic manner.

(2) Nothing in paragraph (1) shall prohibit direct communication by Internet posting or the use of other electronic means to convey clinical laboratory test results by a treating health care professional who ordered the test for his or her patient or by a health care professional acting on behalf of, or with the authorization of, the treating health care professional who ordered the test.

(c) When a patient requests to receive his or her laboratory test results by Internet posting, the health care professional shall advise the patient of any charges that may be assessed directly to the patient or insurer for the service and that the patient may call the health care professional for a more detailed explanation of the laboratory test results when delivered.

(d) The electronic provision of test results under this section shall be in accordance with any applicable federal law governing privacy and security of electronic personal health records. However, any state statute, if enacted, that governs privacy and security of electronic personal health records, shall apply to test results under this section and shall prevail over federal law if federal law permits.

(e) The test results to be reported to the patient pursuant to this section shall be recorded in the patient's medical record, and shall be reported to the patient within a reasonable time period after the test results are received at the offices of the health care professional who requested the test.

(f) Notwithstanding subdivisions (a) and (b), none of the following clinical laboratory test results and any other related results shall be conveyed to a patient by Internet posting or other electronic means:

- (1) HIV antibody test.
- (2) Presence of antigens indicating a hepatitis infection.
- (3) Abusing the use of drugs.
- (4) Test results related to routinely processed tissues, including skin biopsies, Pap smear tests, products of conception, and bone marrow aspirations for morphological evaluation, if they reveal a malignancy.

(g) Patient identifiable test results and health information that have been provided under this section shall not be used for any commercial purpose without the consent of the patient, obtained in a manner consistent with the requirements of Section 56.11 of the Civil Code.

(h) Any third party to whom laboratory test results are disclosed pursuant to this section shall be deemed a provider of administrative services, as that term is used in paragraph (3) of subdivision (c) of Section 56.10 of the Civil Code, and shall be subject to all limitations and penalties applicable to that section.

(i) A patient may not be required to pay any cost, or be charged any fee, for electing to receive his or her laboratory results in any manner other than by Internet posting or other electronic form.

(j) A patient or his or her physician may revoke any consent provided under this section at any time and without penalty, except to the extent that action has been taken in reliance on that consent.

123149. (a) Providers of health services, licensed pursuant to Sections 1205, 1253, 1575, and 1726, that utilize electronic recordkeeping systems only, shall comply with the additional requirements of this section. These additional requirements do not apply to patient records if hard copy versions of the patient records are retained.

(b) Any use of electronic recordkeeping to store patient records shall ensure the safety and integrity of those records at least to the extent of hard copy records. All providers set forth in subdivision (a) shall ensure the safety and integrity of all electronic media used to store patient records by employing an offsite backup storage system, an image mechanism that is able to copy signature documents, and a mechanism to ensure that once a record is input, it is unalterable.

(c) Original hard copies of patient records may be destroyed once the record has been electronically stored.

(d) The printout of the computerized version shall be considered the original as defined in Section 255 of the Evidence Code for purposes of providing copies to patients, the Division of Licensing and Certification, and for introduction into evidence in accordance with Sections 1550 and 1551 of the Evidence Code, in administrative or court proceedings.

(e) Access to electronically stored patient records shall be made available to the Division of Licensing and Certification staff promptly, upon request.

(f) This section does not exempt licensed clinics, health facilities, adult day health care centers, and home health agencies from the requirement of maintaining original copies of patient records that cannot be electronically stored.

(g) Any health care provider subject to this section, choosing to utilize an electronic recordkeeping system, shall develop and implement policies and procedures to include safeguards for confidentiality and unauthorized access to electronically stored patient health records, authentication by electronic signature keys, and systems maintenance.

(h) Nothing contained in this chapter shall affect the existing regulatory requirements for the access, use, disclosure, confidentiality, retention of record contents, and maintenance of health information in patient records by health care providers.

(i) This chapter does not prohibit any provider of health care services from maintaining or retaining patient records electronically.

123149.5. (a) It is the intent of the Legislature that all medical information transmitted during the delivery of health care via telemedicine, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, become part of the patient's medical record maintained by the licensed health care provider.

(b) This section shall not be construed to limit or waive any of the requirements of Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

ATTACHMENT

Agenda Item V. C.

BPC Section 2290.5, Telemedicine

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BUSINESS AND PROFESSIONS CODE SECTION 2290.5
TELEMEDICINE

2290.5. (a) (1) For the purposes of this section, "telemedicine" means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Neither a telephone conversation nor an electronic mail message between a health care practitioner and patient constitutes "telemedicine" for purposes of this section.

(2) For purposes of this section, "interactive" means an audio, video, or data communication involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information.

(b) For the purposes of this section, "health care practitioner" has the same meaning as "licentiate" as defined in paragraph (2) of subdivision (a) of Section 805.

(c) Prior to the delivery of health care via telemedicine, the health care practitioner who has ultimate authority over the care or primary diagnosis of the patient shall obtain verbal and written informed consent from the patient or the patient's legal representative. The informed consent procedure shall ensure that at least all of the following information is given to the patient or the patient's legal representative verbally and in writing:

(1) The patient or the patient's legal representative retains the option to withhold or withdraw consent at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which the patient or the patient's legal representative would otherwise be entitled.

(2) A description of the potential risks, consequences, and benefits of telemedicine.

(3) All existing confidentiality protections apply.

(4) All existing laws regarding patient access to medical information and copies of medical records apply.

(5) Dissemination of any patient identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without the consent of the patient.

(d) A patient or the patient's legal representative shall sign a written statement prior to the delivery of health care via telemedicine, indicating that the patient or the patient's legal representative understands the written information provided pursuant to subdivision (a), and that this information has been discussed with the health care practitioner, or his or her designee.

(e) The written consent statement signed by the patient or the patient's legal representative shall become part of the patient's medical record.

(f) The failure of a health care practitioner to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

(g) All existing laws regarding surrogate decisionmaking shall apply. For purposes of this section, "surrogate decisionmaking" means any decision made in the practice of medicine by a parent or legal representative for a minor or an incapacitated or incompetent individual.

(h) Except as provided in paragraph (3) of subdivision (c), this section shall not apply when the patient is not directly involved in the telemedicine interaction, for example when one health care practitioner consults with another health care practitioner.

(i) This section shall not apply in an emergency situation in which a patient is unable to give informed consent and the representative of that patient is not available in a timely manner.

(j) This section shall not apply to a patient under the jurisdiction of the Department of Corrections or any other correctional facility.

(k) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

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Agenda Item V. E.

Review and Adoption of Board Logo Design

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State of California
Board of Behavioral Sciences

Memorandum

To: Board Members

Date: November 1, 2006

From: Mona C. Maggio
Assistant Executive Officer

Telephone: (916) 574-7841

Subject: **Agenda Item V. F. - Strategic Plan Goal #3 - Promote Higher Professional Standards Through Rigorous Enforcement and Public Policy Changes - Report on Progress**

Goal #3 – Promote higher professional standards through rigorous enforcement and public policy changes.

Objective 3.1 -- Complete Revisions for Continuing Education Laws by December 31, 2006.

Background

The Board's strategic plan identifies the need to "Complete Revisions for Continuing Education Laws by December 31, 2006."

Update

Title 16, CCR, Sections 1816.7 and 1887.7, Delinquency Fees for Continuing Education Providers

This proposal would allow a registered provider of continuing education (PCE) a period of one year from the registration's expiration date in order to renew an expired PCE registration with a \$100 delinquency fee. Currently, when a PCE does not renew the registration prior to its expiration date, the registration is cancelled and a new registration must be obtained. At its June 21, 2006 meeting, the Board's Budget and Efficiency Committee recommended that the Board adopt these proposed regulations. The Board approved this proposal at its meeting on July 27, 2006. Staff submitted the required regulatory documents to OAL in order to have the notice published on September 29, 2006. The regulatory hearing is scheduled for November 16, 2006; the Board will be asked to review and give its approval to this proposal at its meeting on the same day.

Title 16, CCR, Sections 1887(b), 1887.2(a), and 1887.3(a) Continuing Education

Licensees are currently permitted to take an unlimited amount of continuing education (CE) by conventional or online means. However, hours earned through "self-study" courses are limited to one-third of the total required CE hours. This proposal would delete the definition of a self-study course and delete the limitations regarding hours of self-study. The Consumer Protection Committee reviewed this proposal at its September 20, 2006 meeting and recommended minor clarifying edits

to the language. The Board will be asked to review and approve the recommendation to amend the regulations at its meeting on November 16, 2006.

Title 16, CCR Section 1886, Citation and Fine of Continuing Education Providers

This proposal would provide the Board with the authority to issue a citation and fine to a continuing education provider. This proposal is currently on hold due to staff workload considerations.

Objective 3.2 --

Establish a Standard to Measure Quality of Continuing Education by June 30, 2007.

Background

The Board's strategic plan identifies the need to ensure high professional standards for Marriage and Family Therapists (MFT) and Licensed Clinical Social Workers (LCSW). In an effort to meet this objective, the board must develop a way to measure the quality of continuing education (CE) courses and thereby establish a minimum standard that all CE courses must meet to be or continue to be approved as a Board of Behavioral Sciences (BBS) approved provider.

Update

Staff has identified the basic tasks to begin researching this objective. Staff is completing the analysis of the data collection from other six identified entities (BAR Association, California Association of Marriage and Family Therapists (CAMFT), California Society for Clinical Social Work (CSCSW), National Association of Social Workers (NASW), UC Davis Continuing Medical Education, American Association of State Social Work Boards (AASWB) and DCA boards and bureaus). Team members will meet to determine methodologies to measure to the quality of CE courses and minimum uniform standards.

Objective 3.3 --

Complete 12 Substantive Changes in Laws and Regulations by January 1, 2008.

Background

The Board's strategic plan identifies the need to "Complete 12 substantive changes in laws and regulations by January 1, 2008."

Update

The Board sponsored Senate Bill 1475 (Figueroa), which updates the Licensed Educational Psychologist statutes as follows:

- General reorganization and revision
- Removal of obsolete provisions
- Modernizes statutes relating to licensure, scope of practice, continuing education, and enforcement
- Creates better consistency with the Marriage and Family Therapist and Licensed Clinical Social Worker practice acts.

These updates include:

- Establishing a new continuing education requirement. A minimum of 60 hours will be required for each two-year period. LEPs who received their school psychologist credential on or after July 1, 1994 will be exempt from this CE requirement. This is because licensees credentialed after that date are required by the Commission on Teacher Credentialing to complete equivalent hours of professional development. Though the statute becomes effective on January 1, 2007, it will not take effect until the board implements regulations.
- Requires all compensation received by an LEP to be in relation to professional counseling services actually provided, and prohibits any fee from being charged for collaboration between two or more licensees in a case except when disclosure of the fee has been made to the client. The definition of unprofessional conduct has also been revised for consistency with the MFT and LCSW practice acts.

2. Updates the scope of practice. These changes are not intended to expand the scope of services provided by LEPs, but are designed to better define those services and establish a clear parallel with the services authorized by a Pupil Personnel Services Credential in school psychology. The new LEP scope of practice reads as follows:

“The practice of educational psychology is the performance of any of the following professional functions pertaining to academic learning processes or the education system or both:

- (a) Education evaluation.
- (b) Diagnosis of psychological disorders related to academic learning processes.
- (c) Administration of diagnostic tests related to academic learning processes including tests of academic ability, learning patterns, achievement, motivation, and personality factors.
- (d) Interpretation of diagnostic test related to academic learning processes including tests of academic ability, learning patterns, achievement, motivation, and personality factors.
- (e) Providing psychological counseling for individuals, groups and families.
- (f) Consultation with other educators and parents on issues of social development, behavioral and academic difficulties.
- (g) Conducting psycho educational assessments for purposes of identifying special needs,
- (h) Developing treatment programs and strategies to address problems of adjustment.
- (i) Coordinating intervention strategies for management of individual crises.”

There have also been some minor revisions to the requirements for licensure, most of which are designed to remove former grand-parenting provisions. The most significant change is that the hours of experience required for licensure will not be credited if the hours were gained more than six years prior to the date of application to the board.

Additionally, the board will no longer have the authority to accept degrees or experience types other than those named in statute.

This bill also reorganizes the LEP statutes into a new chapter (13.5) of the Business and Professions Code. This was needed because the LEP statutes were previously part of chapter 13, which pertains to MFTs.

This bill also makes some minor changes to the Board's administration statutes, including removal of obsolete provisions and reorganization for better clarity, including placement into a new chapter (13.7) of the Business and Professions Code. This was needed because the administration statutes were previously part of chapter 14, which pertains to LCSWs.

The bill also makes some changes regarding portability of licensure for clinical social workers licensed in another state, as follows:

- Waives the supervised experience requirement for an applicant who has been licensed for at least four years as a clinical social worker in another state.
- Permits an applicant licensed as a clinical social worker for less than four years in another state to count a portion of his or her experience as a licensee toward California's supervised experience requirements.
- Requires out-of-state applicants to have a clean disciplinary record in any state in which they have been licensed.

Board staff conducted a national review of clinical social work licensure, and found that the requirements for licensure in other states are comparable to California's education and experience requirements and in some cases are more stringent. This change was needed due to the delay that certain requirements were creating for persons licensed as a clinical social worker in another state who are trying to become licensed in California. One example is that the supervised experience had to be completed within the past six years, regardless of how long the person was licensed.

STATUS: This bill has been signed by the Governor, and takes effect January 1, 2007.

The Board sponsored Assembly Bill 1852 (Yee), *Licensed Mental Health Service Provider Education Program*: This bill allows marriage and family therapist interns and associate clinical social workers to be eligible to apply for educational loan repayment under the Licensed Mental Health Service Provider Education Program (Program). The bill also provides technical cleanup of the Program's statute. This bill takes effect on January 1, 2007; however, loan reimbursement will not be available until the Health Professions Education Program implements regulations. The Health Professions Education Program, a division of the Office of Statewide Health Planning and Development, administers this program.

STATUS: This bill was signed by the Governor and takes effect January 1, 2007.

The Board has also approved several substantive regulatory changes, currently in process and expected to be complete by early 2007:

Title 16, CCR Section 1886.40, Citations and Fines

The purpose of this regulatory proposal was to provide the Board with the authority to issue fines between \$2,501 and \$5,000 for specified "citable offenses" or violations of the statutes and regulations enforced by the Board. The final rulemaking packet was filed with the Office of Administrative Law (OAL) on June 27, 2006 and was approved. The regulatory changes became effective on September 3, 2006.

Title 16, CCR Section 1803, Delegation of Authority to the Executive Officer

This proposal would allow the Board's executive officer to sign orders to compel a physical or mental evaluation of a Board licensee or registrant as part of an investigation of a complaint. A regulatory hearing was held on October 4, 2006 and no public comments were received. The Board will be asked to review and give final approval to this proposal at its meeting on November 16, 2006.

Title 16, CCR Sections 1833.1 and 1870, Supervisor Qualifications

Supervisors of registrants are currently required to have practiced psychotherapy for two out of the five years preceding any supervision. This proposal would allow supervisors to count time spent directly supervising persons who perform psychotherapy toward this requirement and delete the requirement that supervisors of MFT Interns and Trainees average 5 hours of client contact per week for two out of the five years prior to supervising. At its April 19, 2006 meeting, the Board's Policy and Advocacy Committee voted to recommend proposed language to the Board. The Board reviewed the proposal at its May 18, 2006 meeting and sent it back to the Committee for further work. At its June 28, 2006 meeting, the Committee recommended to the Board that the original language of the proposal be retained and additionally recommended to delete the requirement that supervisors of MFT Interns average 5 hours of client contact per week for two out of the five years prior to supervising. The Board approved this proposal at its meeting on July 27, 2006. Staff submitted the required regulatory documents to OAL in order to have the notice published on September 29, 2006. The regulatory hearing is scheduled for November 16, 2006; the Board will be asked to review and give approval to this proposal at its meeting on the same day.

Title 16, CCR, Technical Cleanup - Licensed Educational Psychologists and Board Administration

This proposal would make technical and editorial changes to the Board's regulations in line with statutory changes proposed under SB 1475 that will update the Board's Licensed Educational Psychologist and Administration statutes. At its June 28, 2006 meeting, the Board's Policy and Advocacy Committee recommended that the Board adopt these proposed regulations. The Board approved this proposal at its

meeting on July 27, 2006. Staff submitted the required regulatory documents to OAL in order to have the notice published on September 29, 2006. The regulatory hearing is scheduled for November 16, 2006; the Board will be asked to review and give approval to this proposal at its meeting on the same day.

Title 16, CCR Sections 1806 and 1833.3, Abandonment of Application Files

Section 1806 currently requires candidates to take an examination within one year of notification of eligibility to take the examination. Section 1833.3 currently requires applicants who fail an examination to retake that examination within one year from the date of the failure. However, candidates who fail are provided with a notice of eligibility 180 days from the date of failure, so both sections apply and reflect two different time frames. This regulatory proposal would resolve the conflict between these two regulations, providing all candidates with a one-year period in which to take an examination to avoid abandonment of their application. At its June 28, 2006 meeting, the Board's Policy and Advocacy Committee recommended that the Board adopt these proposed regulations. The Board approved this proposal at its meeting on July 27, 2006. Staff submitted the required regulatory documents to OAL in order to have the notice published on September 29, 2006. The regulatory hearing is scheduled for November 16, 2006; the Board will be asked to review and give approval to this proposal at its meeting on the same day.

Title 16, CCR, Fees

This proposal would make technical changes to the Board's regulations regarding fees. These changes would conform the Board's regulations to the non-substantive statutory changes the Budget and Efficiency Committee is recommending to the Board regarding fees, renewals, and inactive licenses. At its June 28, 2006 meeting, the Board's Policy and Advocacy Committee recommended that the Board adopt these proposed regulations. The Board approved this proposal at its meeting on July 27, 2006. Staff submitted the required regulatory documents to OAL in order to have the notice published on September 29, 2006. The regulatory hearing is scheduled for November 16, 2006; the Board will be asked to review and give approval to this proposal at its meeting on the same day.

Objective 3.4 -- Advocate for Five Laws that Protect the Privacy of Client/Therapist Relationships by December 31, 2010.

Background

The Board's strategic plan identifies the need to "Advocate for five laws that protect the privacy of client/therapist relationships by December 2010."

Update

The Board took a position of support on Assembly Bill 3013 (Koretz). This bill strengthens patient confidentiality laws by conforming California law to provisions of the Health Insurance Portability and Accountability Act (HIPAA) which limit the release of patient information, provide the patient the opportunity to prohibit such a

release, and permit the health care provider to make judgments regarding releases in emergency situations.

STATUS: This bill takes effect January 1, 2007

The Board is continuing to watch a number of bills, including the following:

- Assembly Bill 2257 (Committee on Business and Professions) – This bill requires a psychologist to retain patient records for 7 years from the patient's discharge date. This bill was signed by the Governor and takes effect January 1, 2007

Board staff will monitor legislation and identify any that has the potential to protect the privacy of client/therapist relationships beginning with the 2007 legislative season. Any such legislation will be analyzed and brought before the Policy and Advocacy Committee who will make a recommendation to the Board whether to support the bill and when needed, suggest amendments.

Objective 3.5 --

Provide Four Educational Opportunities for Division of Investigation (DOI) and The Office of the Attorney General (AG) Regarding the Board of Behavioral Sciences (BBS) and Its Licensees by June 30, 2008.

Background

Team members identified the educational opportunities as training for DOI investigators and the Deputy Attorneys General regarding the Board's scope of authority, licensee scope of practice and the necessary requirements to conduct investigations and prosecute cases. The training will be conducted by the Executive Officer, representatives from the Department of Justice and the Board's Enforcement Unit.

Current Status:

Team members have received training material samples from other boards to assist in developing the training program for DOI investigators and the Deputy Attorneys General. DOI investigators will participate in the Board's Subject Matter Expert Training in January 2007.

Objective 3.6 --

Reduce time in which BBS cases are investigated and processed by DOI and AG by 30% by June 30, 2010.

Background

Cases sent to the Division of Investigation (DOI) for formal investigation take an average of 9 months to one year for completion. The Administrative Hearing process averages another year for a proposed decision to be rendered and come before the Board. It is the goal of this objective to shorten the processing time for investigation and prosecution of cases to meet the Board's mandate to protect the public health, safety and welfare.

Status

In September 2006, Mona Maggio met with Kathy Door, Chief and Bill Holland Deputy with DOI for a client services meeting. The meeting provided an opportunity for the Chief to share upcoming changes within DOI. Chief Door announced that she would be leaving DOI in November 2006, she accepted a position with the Department of Motor Vehicles as the Deputy Chief of Investigations. Deputy Chief Holland is currently going through a background investigation for a position as a special investigator with the Department of Justice. Rex Cowart and Danny Elias both senior investigators with DOI will serve in the administrative roles in the interim until a new chief and deputy chief are hired.

DOI created Request for Service Guidelines in order to help serve its clients better. The guidelines request the following:

- Licensed probation checks should not be referred to DOI. However, Board staff are welcome to use DOI field offices to conduct probation checks. This does not impact BBS as enforcement staff serve as the probation monitors.
- Complaints by anonymous victims regarding unprofessional conduct, and negligence/incompetence should not be referred to DOI. Again this does not pertain to the BBS.
- Complaints of unlicensed activity by anonymous persons should not be referred to DOI. Board staff may consider sending an information notice, warning or citation and fine to the subject. BBS currently follows this guideline.
- Depending on the severity of the incident, cases where the incident has occurred one year prior to the request or service should not be referred. Ms. Maggio addressed that this guideline is a concern as many of our complaints are received more than a year after the alleged violation(s) has occurred. This is especially true in cases of sexual misconduct with a therapist. BBS will continue to send cases to DOI when deemed necessary and not be held to the one year guideline.
- Prior to referring negligence/incompetence cases to DOI, board staff should obtain the complainant's patient records and have them reviewed by the Board consultant to determine the need for further investigation. This guideline may also be a concern. If staff can obtain a release(s) from all parties and gather the patient records, insurance billing forms and other materials and we have a certification that the materials are true, accurate and complete, then we can refer to an expert to determine whether the records demonstrate unprofessional conduct. However, the problem is that in therapy cases the records do not answer all of the questions. Therapist cases require detailed interviews of the victim and all persons who can corroborate the victim's story and investigators have special training in interviewing and writing reports. Another issue is that many places request a subpoena for their records, even with a release. Ms. Maggio explained during the meeting that the BBS's enforcement staff make every attempt to obtain all documents and materials and scrutinize the cases prior to sending them to DOI.

- Criminal cases, cases of sexual misconduct, drug diversion and serious injury should continue to be referred and are given the highest priority.

DOI is automating its billing logs. Investigators will be able to input the hours worked and clients will be able to access to see the status of the cases and hours worked.

DOI submitted two budget change proposals (BCP). One BCP requests adding two investigators to the internal affairs division and the other BCP requests adding one investigator and two analysts to a newly created unit called "Infield Assist and Case Closure Unit". This unit will help investigators gather documents, locate witnesses, track data and determine and measure end results. If the BCPs are approved, the positions will be available in July 2007.

DOI currently has 1500 cases statewide, which 50 are BBS cases compared to the 940 cases from the Board of Registered Nursing.

Objective 3.7 --

Complete Annual Review of Examination Program and report the Results at a Public Meeting.

Background/Status

- Staff is currently working with the Office of Examination Resources (OER) on the MFT occupational analysis.
- A presentation on the Board's Licensing and Examination Programs is given each year at the February Board meeting.
- Staff meets regularly with the OER to discuss the Board's current examination program, pass rates, examination development workshops and the examination vendor Thompson/Prometric.

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**State of California
Board of Behavioral Sciences**

M e m o r a n d u m

To: Consumer Protection Committee

Date: November 3, 2006

From: Mona C. Maggio
Assistant Executive Officer

Telephone: (916) 574-7841

Subject: Agenda Item V F - Strategic Plan Goal #1 - Report on Progress

Goal #1 - Communicate Effectively With the Public and Mental Health Professionals.

Objective 1.1 -- Provide Six Educational Opportunities for Stakeholders and Staff on BBS Budget by July 30, 2006.

Background

In an effort to demystify the state budget process, staff will present updates as part of its educational opportunities to its stakeholders.

Update

Ms. Gershon prepared an article *Understanding the Board's Budget* for the Spring 2006 newsletter. A presentation tailored to the public is included during outreach presentations, such as student and educator forums. Updates regarding the Board's budget are presented at Board and Committee Meetings.

Additionally, Ms. Gershon will give then annual overview of the Board's budget at the November 2006 meeting.

Staff has identified this objective as being met.

Objective 1.2 -- Distribute a Handbook Outlining Licensing Requirements by December 31, 2006 to 100% of California Schools Offering Qualifying Degrees.

Background

The Board identified a need to provide students and educators with an outline of examination and licensing requirements to assist students in their education and career development.

Update

The text for the MFT and LCSW handbooks has been finalized. Currently, the project is in the hands of BP Cubed's graphic designer. The designer will add graphics and make suggestions for layout of the text. The handbooks will be presented to the Committee at its next meeting. A LEP

Student Handbook is currently in the early stages of development.

Objective 1.3 -- Distribute Consumer Publication Regarding Professions Licensed by the Board by June 30, 2007.

Background

The Board identified a need to provide information to its stakeholders regarding various services, i.e., complaint process, licensing process, examinations, how to select a therapist, etc.

Update

BP Cubed and the Board staff have finalized the Communication Plan. This plan calls for the development of various collateral materials, one of which is a consumer-targeted publication regarding the Board. The target date for the release of this publication is March 2007.

Objective 1.4 - Achieve 60% on Customer Service Satisfaction Surveys by June 30, 2008.

Background

At the Strategic Planning meetings, it was determined that good customer service is essential in meeting goal #1: to Communicate Effectively With the Public and Mental Health Professionals. This objective was created to measure the level of customer satisfaction with Board activities. The purpose of the surveys, which is to aid in the Board's goal of improving customer satisfaction levels.

Status

The Web based Customer Service Satisfaction Survey has generated 426 responses through October 31st 2006. Thus far, 61% of respondents are satisfied.

Objective 1.5 -- Participate Four Times Each year in Mental Health Public Outreach Events Through June 30, 2010.

Background

In an effort to expand its outreach and provide effective communication to the public and mental health professionals, the Board determined that it should participate in mental health public outreach events four or more times per year.

Status

On September 28th 2006, Paul Riches and Sean O'Connor attended the California Social Work Education Committee meeting in Sacramento. Mr. Riches gave a brief presentation to the audience of educators and professionals. On October 16th, 17th, and 24th, Mr. O'Connor presented information on MFT licensure at Notre Dame De Namur University, the California Institute of Integral Studies, and Pacific Oaks College, respectively. On October 20th and 21st, Mr. O'Connor attended the NASW CE Fair held in South San Francisco. Mr. O'Connor passed out information and answered questions from those in attendance.

The Board has various events scheduled through the end of the year and in

to 2007, including 7 scheduled school presentations at LCSW and MFT schools. More school presentation dates for the spring will be announced in the coming months. Mr. O'Connor and Board Member Joan Walmsley will present information at the mental health agency Human Options on November 30th 2006, and Mr. O'Connor will present information at the mental health agency Laura's House on January 22nd, 2007. Mr. O'Connor will also attend the CAMFT and NASW annual conferences in Spring 2007.

BP Cubed will continue to work with Mr. O'Connor on identifying key events and developing collateral materials for outreach events. BP Cubed will present at the Board Meeting.

Objective 1.6 -- Review and Revise Website Content Four Times Per Year.

Staff has identified this as an ongoing objective and recommends the "review and revise website content" be completed every six months rather four times per year. This will be completed so that it coincides with effective dates on legislation that may impacts board operations, procedures, contents, processes, forms, etc.

Background

One of the goals of the 2005 Strategic Plan is to communicate effectively with the public and mental health professionals. The BBS Website provides valuable information regarding various Board services, regulatory functions, examinations, enforcement, licensing, licensee status, etc.

Status

Website content is being reviewed on a regular basis and edits are being made accordingly.

In addition, over the next several months the website will be undergoing some major changes. One change will be the way in which the back end of the site is programmed for accessibility. Other changes are to meet new state standards for usability and visual design with all state agencies, as well as compliance with SB796, which requires various navigational and content issues be completed by January 2007. Our website will also be undergoing a restructure and placement of where information is found in an effort to assist our audiences in locating pertinent information that they may need.

Objective 1.7

Student Outreach

Staff determined that the success of the Board's Student Outreach Program warranted consideration for the adoption of a new student outreach objective to the Strategic Plan.

At its May 18, 2006 meeting, the Board adopted a new Strategic Plan Objective 1.7 – Student Outreach.

Objective defined: Conduct 25 student outreach events per fiscal year at qualifying degree-granting colleges and universities by June 30, 2010.

Measure: Number of student outreach visits completed in a 12-month period.

Team Members: Sean O'Connor, Kim Madsen

Prospective Goals for Student Outreach

Twenty-five student outreach events a year is an ambitious yet attainable goal. This is feasible from a staff resource standpoint. The Board has approximately 82 qualifying degree-granting institutions, so in a three-year period nearly all could be reached. Some schools have larger student populations; thus, these schools may require more than one visit in a three-year period. The Board will invite schools with smaller student populations to attend presentations at schools in close proximity. For the eight student events conducted thus far, the combined total attendance is approximately 340 students.

The Spring 2006 academic semester is the first full semester in which the Board has had an operational outreach program. Twelve events have been scheduled, eight visits completed. Most student outreach events will occur in the Fall or Spring academic semesters. Some schools have summer programs, so presentations during the summer months will be possible but likely less frequent. The response to the student outreach is overwhelmingly positive.

Status

Mr. O'Connor presented at the following campuses and agencies in September and October 2006:

- The Seneca Center (agency) on September 19th
- CSU, Long Beach (MFT) on September 22nd
- University of Southern California (MFT) on September 29th
- Notre Dame de Namur University (MFT) on October 16th
- California Institute of Integral Studies (MFT) on October 17th
- Pacific Oaks College (MFT) on October 24th

Upcoming presentations include:

- Golden Gate University (MFT) on November 8th
- CSU, Fresno on November 16th
- Human Options (agency) on November 30th
- CSU East Bay (MFT) on December 4th
- Laura's House (agency) on January 22nd, 2007
- University of Southern California (LCSW) on January 23, 2007
- Antioch University (MFT) on January 23, 2007
- UC Berkeley (LCSW) on January 29th, 2007
- CSU East Bay (LCSW) on February 21st, 2007
- CSU, Chico (LCSW) on April 13th, 2007

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Agenda Item V. G.

Enforcement Statistics

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BOARD OF BEHAVIORAL SCIENCES

Overview of Enforcement Activity

Fiscal Years	01/02	02/03	03/04	04/05	05/06	06/07*
Complaints / Cases Opened						
Complaints Received	493	514	560	626	801	194
Criminal Convictions Received	397	384	383	384	455	118
Total Complaints Received	890	898	943	1010	1256	312
Investigations Opened	42	25	11	25	44	19
Cases Sent to AG	31	41	17	25	55	4
Filings						
Citations Issued	30	24	19	63	160	43
Accusations Filed	27	17	22	17	29	9
Statement of Issues (SOI's) filed	7	4	4	2	1	1
Temporary Restraining Order	0	0	0	0	0	0
Interim Suspension Orders	0	0	1	0	1	0
Withdrawals/Dismissals						
Accusations Withdrawn or Dismissed	3	1	0	1	1	0
SOI's Withdrawn or Dismissed	1	1	0	0	0	0
Declined by the AG	0	7	3	1	3	1
Disciplinary Decision Outcomes						
Revoked	14	4	10	4	7	2
Revoked, Stayed, Susp & Probation	2	2	1	2	0	1
Revoked, Stayed, Probation	12	6	5	2	4	1
Surrender of License	6	7	7	7	9	1
Suspension	0	0	0	0	0	0
Susp., Stayed, Susp & Prob	0	0	0	0	0	0
Susp., Stayed Probation	0	1	0	0	0	0
Susp & Prob Only	0	0	0	0	0	0
License Probation Only	1	0	0	0	0	0
Reprimand / Repeval	0	1	0	0	0	0
Other Decisions	0	0	0	0	0	0
Total Decisions	35	21	23	15	20	5
Decisions (By Violation Type)						
Fraud	1	1	0	1	0	1
Health & Safety	0	0	0	1	2	0
Sexual Misconduct	13	5	5	5	5	0
Competence / Negligence	1	2	9	2	2	0
Personal Conduct	7	7	3	4	7	2
Unprofessional Conduct	8	4	4	2	4	2
Unlicensed Activity	0	0	0	0	0	0
Other	0	0	0	0	0	0
Violation of Probation	5	2	2	0	0	0

* Fiscal Year Period: 7/1/06 through 09/30/06.

Note: These statistics are for informational purposes only and should not be used as the sole source to analyze the Board's enforcement program.

**BOARD OF BEHAVIORAL SCIENCES
ENFORCEMENT AGING DATA
2006 - 2007 FISCAL YEAR ⁽¹⁾**

	0-3 mo	4-6 mo	7-9 mo	10-12 mo	1-2 years	2-3 years	Over 3 Years	Total
Pending Complaints ⁽²⁾	163	85	34	12	8	0	0	302
Pending Investigations ⁽³⁾	20	4	8	6	9	0	0	47
Total Pending Complaints (Includes Inv) ⁽⁴⁾	183	89	42	18	17	0	0	349
Pending Cases at the AG - Pre Accusation ⁽⁵⁾	5	10	7	1	0	1	0	24
Pending Cases at the AG - Post Accusation ⁽⁶⁾	10	9	6	5	3	0	2	35
Total Pending Cases at the AG's Office	15	19	13	6	3	1	2	59

(1) Pending as of September 30, 2006.

(2) Pending Complaints are those complaints which are not currently being investigated by the Division of Investigation.

(3) Pending Investigations are those complaints which are being investigated by the Division of Investigation.

(4) Total Pending Complaints includes pending complaints and pending investigations.

(5) Pre Accusation are those pending cases at the AG's office where an accusation or statement of issues has not been filed yet.

(6) Post Accusation are those pending cases at the AG's office where a accusation or statement of issues has been filed.

Note: These statistics are for informational purposes only and should not be used as the the sole source to analyze the Board's enforcement program.

BOARD OF BEHAVIORAL SCIENCES
BREAKDOWN OF ENFORCEMENT COMPLAINT ACTIVITY BY LICENSEE POPULATION
2006 - 2007
FISCAL YEAR ⁽¹⁾

	OPENED	COMPLAINTS CLOSED	PENDING	Licenses In Effect (2)	% of Licenses to Pending Complaints
UNLICENSED	29	24	31	n/a	n/a
APPLICANTS	112	116	34	n/a	n/a
CE PROVIDERS	1	0	3	2285	0.13
DUAL LICENSEES (3)	3	4	4	n/a	n/a
DUAL W/BOP (3)	3	4	5	n/a	n/a
ASW	13	15	29	7001	0.41
LCSW	31	41	50	16556	0.30
IMF	26	25	55	10241	0.54
MFT	93	93	138	28355	0.49
LEP	1	0	3	1741	0.17
TOTAL	312	322	352	66179	0.53

- Note:
- (1) Activity is from July 1, 2006 through September 30, 2006. Pending as of September 30, 2006.
 - (2) Licenses in effect as of September 1, 2006. Does not include cancelled, revoked, or voluntary surrender of licenses.
 - (3) Dual licensees are those that hold dual licenses with BBSE. Dual w/BOP are licensed with BBSE and the Board of Psychology.

Note: These statistics are for informational purposes only and should not be used as the the sole source to analyze the Board's enforcement program.

BOARD OF BEHAVIORAL SCIENCES
BREAKDOWN OF ENFORCEMENT COMPLAINT CLOSURES BY TYPE
2006 - 2007
FISCAL YEAR ⁽¹⁾

	Unactionable (2)	Mediated (3)	Citation (4)	Violation (5)	Inv. (6)	District Attorney (7)	Rfrd Disp. (8)	Other (9)	TOTAL
UNLICENSED	22	0	0	1	0	0	0	1	24
APPLICANTS	0	0	0	115	0	0	1	0	116
CE PROVIDER	0	0	0	0	0	0	0	0	0
DUAL LICENSEES (10)	0	0	4	0	0	0	0	0	4
DUAL W/BOP (10)	3	0	1	0	0	0	0	0	4
ASW	10	0	0	2	0	0	0	3	15
LCSW	29	0	10	1	0	0	0	1	41
IMF	11	0	2	9	0	0	0	3	25
MFT	56	0	25	4	4	0	2	2	93
LEP	0	0	0	0	0	0	0	0	0
TOTAL	131	0	42	132	4	0	3	10	322

41% Unactionable

59% Actionable

Note:

- (1) Closure activity is from July 1, 2006 through September 30, 2006.
- (2) Unactionable: Complaints which after review are closed no violation, insufficient evidence, no jurisdiction etc.
- (3) Mediated: Complaints which have no violation, but where a resolution was reached between parties.
- (4) Citation: Complaints in which after review, violations have been found and the complaint was closed upon the issuance of a citation.
- (5) Violation: Complaints which after review, violations have been found and were closed upon the issuance of a cease and desist or warning letter.
- (6) Inv.: Complaints which were closed after an investigation was conducted.
- (7) District Attorney: Complaints which, after review, a determination is made that the matter should be referred to the DA's office.
- (8) Rfrd Disp: Complaints which are referred directly to the Attorney General's office for disciplinary action (no investigation was required).
- (9) Other: Complaints closed in any manner which does not fit within one of the other categories.
- (10) Dual licensees are those that hold dual licenses with BBSE. Dual w/BOP are licensed with BBSE and the Board of Psychology.

Note: These statistics are for informational purposes only and should not be used as the the sole source to analyze the Board's enforcement program.

BOARD OF BEHAVIORAL SCIENCES
CATEGORY OF PENDING COMPLAINTS
As of September 30, 2006

AGENCY CATEGORY	CE	UL	AP	DL	DP	AS	LC	IM	MF	LEP	TOTAL
Fraud	0	0	0	0	0	0	1	0	1	0	2
Fraudulent License	0	0	1	0	0	0	0	0	0	0	1
Insurance, Medi-Cal	0	0	0	0	0	0	0	0	0	0	0
Non-Jurisdictional	0	1	0	0	0	0	0	1	3	0	5
Custody	0	1	0	1	1	0	1	0	11	0	15
Fee Disputes	0	0	0	0	1	0	0	0	3	0	4
Exempt from licensure	0	3	0	1	0	1	0	1	4	0	10
Negligence	0	0	0	0	0	0	0	0	1	0	1
Beyond Scope	0	0	0	0	0	0	1	0	1	0	2
Dual Relationship	0	0	0	0	0	0	0	0	0	0	0
Abandonment	0	0	0	0	0	0	3	0	1	0	4
Improper Supervision	0	0	0	0	2	0	1	0	2	0	5
Misdiagnosis	0	0	0	0	0	0	0	0	1	0	1
Failure/Report Abuse	0	0	0	0	0	0	0	0	0	0	0
Aiding & Abetting	0	0	0	0	0	0	0	0	2	0	2
Other	0	0	0	0	0	0	0	0	1	0	1
Mental Illness	0	0	0	0	0	1	1	0	2	0	4
Self Use Drugs/Alcohol	0	0	0	0	0	5	2	7	3	0	17
Conviction of Crime	0	0	1	0	0	14	5	16	11	0	47
Unprofessional Conduct	1	0	0	0	1	2	17	14	53	2	90
Sexual Misconduct	0	0	0	0	0	0	0	4	7	1	12
Breach of Confidentiality	0	0	0	0	0	1	4	2	7	0	14
Emotional/Phys. Harm	0	0	0	1	0	0	1	1	0	0	3
Advertising / Misrepresentation	1	3	0	0	0	2	0	5	3	0	14
Unlicensed Practice	1	23	0	0	0	2	1	3	0	0	30
Repressed Memory	0	0	0	0	0	0	0	0	0	0	0
Third Party Complaint	0	0	0	1	0	1	5	1	10	0	18
Unsafe/Sanitary Conditions	0	0	0	0	0	0	0	0	0	0	0
Discipline by Another State	0	0	2	0	0	0	0	1	0	0	3
Criminal Convictions - Renewal Reported	0	0	0	0	0	0	2	0	0	0	2
Non Compliance with CE Audit	0	0	0	0	0	0	5	0	11	0	16
Applicant Referral for Criminal Conviction	0	0	30	0	0	0	0	0	0	0	30
Subvert Licensing Exam	0	0	0	0	0	0	0	0	0	0	0
TOTAL	3	31	34	4	5	29	50	56	138	3	353

Note: These statistics are for informational purposes only and should not be used as the the sole source to analyze the Board's enforcement program.

BOARD OF BEHAVIORAL SCIENCES
BREAKDOWN OF ENFORCEMENT ACTIVITY - CASES AT THE AG'S OFFICE
BY LICENSEE POPULATION
2006 - 2007 FISCAL YEAR ⁽¹⁾

	PENDING	Licenses In Effect (2)	% of Licenses to Pending Cases
UNLICENSED	0	n/a	n/a
APPLICANTS	4	n/a	n/a
SUSEQUENT DISP. (3)	3	n/a	n/a
DUAL LICENSEES (4)	1	n/a	n/a
DUAL W/BOP (4)	4	n/a	n/a
CE PROVIDERS	0	2265	0.00
ASW	2	7001	0.03
LCSW	10	16556	0.06
IMF	9	10241	0.09
MFT	26	28355	0.09
LEP	0	1741	0.00
TOTAL	59	66159	0.09

- Note:
- (1) Pending as of September 30, 2006.
 - (2) Licenses in effect as of September 1, 2006. Does not include cancelled, revoked, or voluntary surrender of licenses.
 - (3) Subsequent Discipline for violation of probation.
 - (4) Dual licensees are those that hold dual licenses with BBSE. Dual w/BOP are licensed with BBSE and the Board of Psychology.

Note: These statistics are for informational purposes only and should not be used as the the sole source to analyze the Board's enforcement program.

**BOARD OF BEHAVIORAL SCIENCES
 CATEGORY TYPES OF DISCIPLINARY ACTION TAKEN
 2006 - 2007
 FISCAL YEAR ***

		MFT IMF	LCSW AWS	LEP	APPLICANT
REVOC. STAYED: PROB ONLY					
Unprofessional Conduct		1			
Aiding and Abetting					
Sexual Misconduct					
Discipline by Another State Agency					
Conviction of a Crime					
Subtotal	1	1	0	0	0
REVOC. STAYED: PROB, SUSPENSION					
Fraud		1			
Subtotal	1	1	0	0	0
REVOKED					
Improper Supervision					
Discipline by Another State Agency					
Conviction of a Crime		1	1		
Sexual Misconduct					
Subtotal	2	1	1	0	0
SURRENDER OF LICENSE					
Unprofessional Conduct			1		
Mental Illness					
Emotional / Physical Harm					
Sexual Misconduct					
Conviction of a Crime					
Subtotal	1	0	1	0	0
TOTAL	5	3	2	0	0

* Time frame: July 1, 2006 through September 30, 2006

Note: These statistics are for informational purposes only and should not be used as the the sole source to analyze the Board's enforcement program.

**BOARD OF BEHAVIORAL SCIENCES
CITATIONS ISSUED BY CATEGORY**

	02/03	03/04	04/05	05/06	06/07*
Agency Category Types					
Sexual Misconduct					1
Improper Supervision	1	1	2		4
Aiding & Abetting				1	
Failure/Report Abuse	1	1			
Breach of Confidence	2	6	5	5	1
Advertising/Misrepresentation	1	1	1		
Unlicensed Practice	4	3	7	2	
Failure Report Conviction on Renewal	2				1
Non Compliance with CE Audit	12	6	44	148	35
Failure Report Conviction on Application	1		1	1	
Subvert Licensing Exam		1			
Practicing Beyond Scope			1		
Client Abandonment				1	
Unprofessional Conduct			2	2	1
TOTAL	24	19	63	160	43

	02/03	03/04	04/05	05/06	06/07*
Number Citations Ordered	24	19	63	160	43
Fines Assessed				\$61,650.00	\$19,450.00
Fines Collected (1)				\$37,150.00	\$10,150.00

(1) May reflect collection of fines ordered in previous fiscal years.

* 06/07 Fiscal Year through: September 30, 2006

Note: These statistics are for informational purposes only and should not be used as the the sole source to analyze the Board's enforcement program.

**BOARD OF BEHAVIORAL SCIENCES
RECOVERY COSTS**

	02/03	03/04	04/05	05/06	06/07*
Number Cases Ordered	12	9	12	11	4
Total Amount Ordered	\$36,258.50	\$25,497.50	\$73,791.25	\$47,751.25	\$29,676.50
Stipulation - Revocation (1)				\$1,320.00	\$1,350.50
Stipulation - Voluntary Surrender (2)				\$36,008.25	\$11,286.50
Stipulation - Probation				\$1,500.00	\$17,039.50
Decision - Revocation				\$6,410.50	
Decision - Probation				\$2,512.50	
Total Amount Collected (3)	\$57,867.25	\$20,600.08	\$23,791.89	\$15,168.57	\$3,362.50
Intercepted by FTB Program				\$314.73	
Cost Collected in Payments				\$8,058.34	\$1,323.00
Cost Collected in Lump Sum				\$6,795.50	\$2,039.50

(1) Cost recovery only required if the respondent pursues reinstatement (may never be recovered).

(2) Cost recovery only required if the respondent reapplies for licensure (may never be recovered).

(3) May reflect collection of cost recovery ordered in previous fiscal years.

* 06/07 Fiscal Year through: September 30, 2006

Note: These statistics are for informational purposes only and should not be used as the the sole source to analyze the Board's enforcement program.

**BOARD OF BEHAVIORAL SCIENCES
REIMBURSEMENT OF PROBATION PROGRAM**

	02/03	03/04	04/05	05/06	06/07 *
# Cases Ordered		1	3	4	2
Amount Ordered Per Year (\$1,200)		\$6,000.00	\$16,800.00	\$19,200.00	\$12,000.00
Amount Collected		0	\$1,900.00	\$3,800.00	\$1,400.00
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* 06/07 Fiscal Year through: September 30, 2006

Note: These statistics are for informational purposes only and should not be used as the the sole source to analyze the Board's enforcement program.